

Yaman Salahi (SBN 288752)  
ysalahi@edelson.com  
EDELSON PC  
150 California Street, 18th Floor  
San Francisco, California 94111  
Tel: 415.212.9300  
Fax: 415.373.9435

Natasha J. Fernández-Silber (*pro hac vice forthcoming*)\*  
nfernandezsilber@edelson.com  
Julian Zhu (SBN 342744)  
jzhu@edelson.com  
EDELSON PC  
350 North LaSalle Street, 14th Floor  
Chicago, Illinois 60654  
Tel: 773.389.2242  
Fax: 312.589.6378  
\* Admitted in Michigan and New York only

*Counsel for Plaintiff Panoramic Medicine and the Proposed Class*

**UNITED STATES DISTRICT COURT  
NORTHERN DISTRICT OF CALIFORNIA  
SAN FRANCISCO DIVISION**

CURTIS F. ROBINSON, M.D., INC., d/b/  
a/ PANORAMIC MEDICINE, on behalf of  
itself and others similarly situated,

*Plaintiffs*

v.

MULTIPLAN, INC., a New York  
corporation, AETNA, INC., a Delaware  
corporation, THE CIGNA GROUP, a  
Delaware corporation, and  
UNITEDHEALTH GROUP  
INCORPORATED, a Delaware  
corporation,

*Defendants.*

Case No. \_\_\_\_-cv-\_\_\_\_

**CLASS ACTION COMPLAINT**

**JURY TRIAL DEMAND**

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## I. INTRODUCTION

1. This action is brought on behalf of a proposed Class of physicians and other healthcare providers (“Providers”) to challenge a cartel among insurance companies (“Insurers”)—with and through the data analytics firm MultiPlan, Inc. (“MultiPlan”)—to artificially reduce reimbursement rates paid to Providers for out-of-network (“OON”) healthcare claims (the “MultiPlan Cartel”).

2. The difference between “out-of-network” and “in-network” claims (and the rates at which they are reimbursed by insurers) stems from healthcare providers’ contractual agreements with insurance companies. In-network providers have agreed to accept pre-negotiated, heavily discounted contract rates for their services, which are set by the insurers, in exchange for access to their plan members (often called “patient steerage”). Conversely, out-of-network providers have declined to enter into these agreements (often because the in-network rates offered are unreasonably low) and are free to set prices based on what the market can bear.

3. Patients often prefer (and in some cases require) treatment from out-of-network providers, including in cases of emergency, where an established patient-doctor relationship exists, where in-network options are lacking, or where highly specialized care is needed. Given the persistent consumer demand for out-of-network care options, many insurance plans offer out-of-network coverage to plan members (or “subscribers”). In fact, out-of-network benefits are the defining feature of the nation’s most popular insurance plan type: the preferred provider organization (“PPO”).

4. Relative to other plan types, like health management organizations (“HMOs”), PPOs command higher premiums in part because they afford their subscribers the freedom to see any provider of their choosing (assuming they are willing to incur increased out-of-pocket costs for out-of-network care). HMOs, by contrast, typically only cover services performed by “in-network” providers.

5. Under normal market conditions, insurers are incentivized to ensure that PPO subscribers (who are paying a premium relative to HMO subscribers to obtain out-

1 of-network benefits) have access to quality out-of-network care options, including by  
2 paying providers competitive reimbursement rates. Insurers understand that paying  
3 below-market reimbursement rates might result in providers either (a) refusing to treat  
4 their subscribers on an out-of-network basis or (b) billing those subscribers for the  
5 portions of their claims not covered by insurance (a process known as “balance billing”).  
6 When this occurs, subscribers are functionally denied the full value of the out-of-  
7 network coverage they’ve paid for and may look to change plans. To avoid losing these  
8 subscribers, insurers have a strong unilateral economic interest in paying competitive  
9 out-of-network reimbursement rates, and in competing on that basis to satisfy both  
10 subscribers and providers.

11 6. However, insurers’ independent, short-term economic self-interest in  
12 competing for out-of-network providers (to avoid subscriber loss) conflicts with their  
13 collective, long-term interest in reducing overall out-of-network costs. This presents  
14 what’s known as a collective action problem: To achieve the collective goal of reducing  
15 industry-wide out-of-network costs, insurers must work together to set rates. But such  
16 coordination is both (a) logistically complex (given the number of claims, services, and  
17 insurers involved) and (b) difficult to enforce (given each insurer’s individual incentive  
18 to undercut the competition by offering better out-of-network coverage through the  
19 provision of fair, competitive reimbursement rates to providers).

20 7. The MultiPlan Cartel allows insurers to overcome this collective action  
21 problem (albeit in violation of the antitrust laws). Rather than setting their out-of-  
22 network reimbursement rates independently, most of the nation’s insurers—roughly  
23 700 out of 1,100 total (including all 15 of the largest insurers)—now outsource this rate-  
24 setting function to a common entity, MultiPlan. By acting collectively through  
25 MultiPlan, insurers (including the Insurer Defendants) effectively eliminate  
26 competition between themselves for out-of-network provider services.

27 8. As part of this scheme, insurers are required and agree to provide  
28 MultiPlan with proprietary, competitively sensitive information (including claims

1 pricing data and reimbursement strategies). This data enables MultiPlan to coordinate  
2 and suppress industry-wide reimbursement rates. As MultiPlan boasts, in order to set  
3 rates for the industry, it “leverages reimbursement data from millions of claims” to help  
4 insurers reprice out-of-network claims by “remov[ing] the guesswork.” This is code for  
5 unlawful coordination on prices through the collection of each insurer’s otherwise  
6 private and competitively sensitive reimbursement data.

7         9. MultiPlan purports to determine out-of-network reimbursement rates  
8 “algorithmically” through a propriety program called “Data iSight.” But Data iSight is  
9 little more than a technological smokescreen for traditional price-fixing. As MultiPlan  
10 admits, the program merely calculates “median reimbursement levels.” However,  
11 MultiPlan ensures that these median calculations are artificially low by feeding the  
12 algorithm junk data, including data reflecting what insurers pay providers on an in-  
13 network basis. As noted above, in-network rates reflect the steep discounts that some  
14 providers agree to offer insurers in exchange for the benefits of network participation  
15 (most notably, increased patient volume). They do not represent reasonable rates of  
16 reimbursement for out-of-network providers, who have entered into no such agreements  
17 with insurers and thus do not stand to gain the benefits of network participation.

18         10. To further suppress and coordinate out-of-network reimbursement levels,  
19 MultiPlan instructs many insurers, including the Insurer Defendants, to enter specific  
20 algorithmic “overrides” such as “Don’t pay more than X% of the Medicare rate.” The  
21 imposition of such rate caps by even a few of the largest insurers (which, given their  
22 market share, are responsible for a huge proportion of all out-of-network claims) results  
23 in rapid downward shifts in industry-wide reimbursement levels. Reimbursements  
24 paid to providers based on these artificial caps become the very data points MultiPlan  
25 then feeds its algorithm to calculate median reimbursement levels in the future. Once  
26 the market resets based upon these new, suppressed levels of reimbursement,  
27 MultiPlan can instruct insurers to enter even lower rate caps—all while assuring them  
28

1 that they'll remain (in the words of one MultiPlan executive) in the "middle of the pack"  
2 as compared to competitors, thus avoiding competitive harms.

3 11. MultiPlan does not stop there. To ensure its fixed reimbursement rates  
4 hold, MultiPlan negotiates with providers on behalf of its insurer clients, who agree to  
5 honor MultiPlan's negotiated rates. In over 95% of cases, providers accept the initial  
6 offer made by MultiPlan, and agree as a condition of payment not to balance bill  
7 patients for the unpaid portions of claims. As a result, in virtually all cases, the  
8 MultiPlan rate determination is the final rate of reimbursement, not a mere  
9 "recommendation" to the insurer.

10 12. MultiPlan points to high provider acceptance rates as proof that its  
11 reimbursements are reasonable. But what they actually signal is the existence of a  
12 cartel (and that cartel's collective market power). Providers are forced to accept  
13 unprecedently low reimbursement rates (and to relinquish their right to balance bill)  
14 because virtually all patients are now covered by insurers who coordinate their behavior  
15 through MultiPlan. The leverage that out-of-network providers once had—which was  
16 premised on the ability to discipline individual insurers through balance billing and  
17 service refusal—is gone. That providers have no alternatives confirms that the  
18 MultiPlan Cartel has significant market power; the threat of competition is virtually  
19 non-existent and thus incapable of disciplining the behavior of cartel members.

20 13. The MultiPlan Cartel has resulted in the dramatic suppression of out-of-  
21 network reimbursement rates. The traditional method of calculating OON  
22 reimbursement rates is based on "usual, customary, and reasonable" provider charges,  
23 or "UCR." Under this method, the UCR rate for a particular service is determined by  
24 surveying the amounts providers in a particular geographic market charge for the same  
25 or similar medical services and then selecting an allowable charge amount. Insurers  
26 may calculate this number as they see fit, but typically the UCR rate was set at around  
27 the 80th percentile of what doctors in the same market charge for a particular service.  
28 Today, UCR rates are calculated from objective data compiled by the independent non-

1 profit organization, Fair Health, Inc. (“FAIR”). Unlike MultiPlan, FAIR charges a flat  
2 annual fee to insurers, and is not compensated based on how low it calculates UCR  
3 rates to be.

4 14. MultiPlan, however, has changed the rules of the game by replacing the  
5 UCR method with its own price-coordination scheme. That strategy has paid off for the  
6 Cartel. According to an April 2020 study published by the Office of the New York State  
7 Comptroller, depending on the service provided, reimbursements based on MultiPlan’s  
8 repricing methodology were 1.5 to 49 times lower than reimbursements for the same  
9 services based on the traditional method of calculating rates (*i.e.*, UCR). And whereas  
10 prior to 2016, reimbursement rates typically rose over time, since 2016, they have fallen  
11 each year because of MultiPlan’s price-coordination scheme. Rather than inure to the  
12 benefit of customers and insureds, these “savings” benefit insurance company  
13 executives and stockholders.

14 15. Meanwhile, providers are forced to accept increasingly low reimbursement  
15 amounts for out-of-network services, which often do not even cover their operating  
16 costs. Low out-of-network reimbursement rates can also indirectly suppress in-network  
17 rates, as providers’ ability to profitably treat patients on an out-of-network basis is  
18 crucial for negotiating better in-network rates. By undermining the economic viability  
19 of billing on an out-of-network basis, insurers strip providers of this leverage, further  
20 entrenching lower in-network reimbursement rates. These dynamics have forced many  
21 practices, particularly smaller ones, to shut their doors, to cease offering certain  
22 services, or to join massive hospital conglomerates, leaving patients with fewer and  
23 fewer healthcare options.

24 16. MultiPlan has a direct economic stake in this race to the bottom. For each  
25 claim it reprices, MultiPlan receives a fee from the insurer based on a percentage of the  
26 difference between the initial claim amount and what the insurer pays. In other words,  
27 MultiPlan gets paid more as providers get paid less. The revenues generated by  
28 MultiPlan from its repricing services have gone from \$23 million in 2012, to \$564

1 million in 2020 and \$709 million in 2021. Insurers choose to pay MultiPlan’s high fees  
2 to facilitate their rate-fixing scheme.

3 17. The MultiPlan Cartel dates to roughly 2015, but it is not the first scheme  
4 by insurers to suppress out-of-network reimbursement rates. From the late 1990s to  
5 roughly 2009, insurers fixed these rates through a UnitedHealthcare subsidiary,  
6 Ingenix, Inc. (“Ingenix”), which functionally calculated UCR rates for the industry. But  
7 as a New York Attorney General’s Office (“NYAG”) investigation revealed, Ingenix was  
8 systematically understating UCR, including by polluting its claims database with  
9 discounted in-network payments, as MultiPlan does today. The Ingenix scheme  
10 artificially suppressed OON reimbursement rates by 10-28%, leading to massive  
11 liability. In 2009, twelve insurers (including the “big four”—Blue Cross/Blue Shield,  
12 United, Cigna, and Aetna) settled with NYAG. They agreed to invest hundreds of  
13 millions of dollars in the creation of a new, independent UCR database to replace  
14 Ingenix—which would become FAIR—and refrain from developing or using any  
15 alternative to FAIR for at least five years. The five-year terms of those settlements  
16 ended in 2015 and 2016. When those bans lapsed, insurers shifted away from FAIR  
17 (and from UCR entirely) and began to fix rates again via MultiPlan.

18 18. The conspiracy challenged herein is unlawful under Section 1 of the  
19 Sherman Act. Plaintiff brings this action to recover damages, trebled, as well as  
20 injunctive and other appropriate relief, detailed *infra*, on behalf of itself and all others  
21 similarly situated.

## 22 II. PARTIES

23 19. Plaintiff Curtis F. Robinson M.D., Inc., doing business as (d/b/a) Panoramic  
24 Medicine (“Panoramic Medicine” or “Plaintiff”), is a California corporation located in  
25 Mill Valley, California. Panoramic Medicine is an independently-owned and operated  
26 primary care practice founded and run by Mill Valley-native Curtis Robinson, M.D.  
27 Panoramic Medicine supports individual and community health, wellness, and  
28 longevity through the provision of cutting-edge primary medical care. While Panoramic

1 Medicine participates in several insurance networks, it sometimes treats patients on an  
2 out-of-network basis. For these patients, Plaintiff submits out-of-network claims for  
3 reimbursement, including to insurers who use MultiPlan's out-of-network claims  
4 repricing services and are members of the MultiPlan Cartel. Plaintiff has received  
5 unreasonably low rates of reimbursement on those claims as a result of the unlawful  
6 price-fixing conspiracy alleged herein.

7       20. Defendant MultiPlan, Inc. ("MultiPlan") is a New York corporation. Its  
8 principal place of business is located at 115 Fifth Avenue, 7th Floor, New York, NY  
9 10003. MultiPlan is wholly owned by MultiPlan Holding Corporation. The ultimate  
10 parent company of MultiPlan Holding Corporation is MultiPlan Corporation.  
11 MultiPlan Corporation is a publicly traded entity. MultiPlan, which purports to be a  
12 third-party out-of-network claims repricing service, serves as the conduit by which  
13 cartel members share, *inter alia*, detailed, competitively sensitive, non-public  
14 information.

15       21. MultiPlan has a number of subsidiaries, including Viant, Inc. ("Viant"), a  
16 healthcare cost management company incorporated in Nevada and headquartered in  
17 Illinois, which MultiPlan acquired in 2010; and healthcare cost management companies  
18 National Care Network, LP, incorporated and headquartered in Texas, and its affiliate  
19 National Care Network, LLC, incorporated in Delaware and headquartered in Texas,  
20 which MultiPlan acquired in 2011.

21       22. Until October 2020, MultiPlan was a privately held corporation. In  
22 October 2020, Churchill Capital Corp. III and its related entities acquired MultiPlan,  
23 Inc. and its related entities. Churchill Capital Corp. III is a special-purpose acquisition  
24 company created to raise funds to take a private company public. It is incorporated in  
25 Delaware and headquartered in New York. After completing the acquisition of  
26 MultiPlan, Inc. and its related companies, Churchill Capital Corp. III changed its name  
27 to MultiPlan Corporation.  
28

23. Defendant Aetna, Inc. (“Aetna”), a subsidiary of CVS Health Corporation, is one of the largest commercial health insurance payers in the United States. It has a commercial insurance network that pays in-network and out-of-network claims from healthcare providers in all 50 states and the District of Columbia. It is a Delaware corporation headquartered in Hartford, Connecticut. Aetna is the parent company, or otherwise affiliated or related company, to various commercial health insurance plans and prescription drug plans that operate in the United States. Those plans issue insurance or provide administrative services concerning healthcare claims in the form of (1) fully insured commercial health insurance plans, (2) self-funded administrative service only health plans, (3) hybrid-funded health plans, (4) Medicare Advantage plans, and (5) Medicaid plans. Aetna is a member of the MultiPlan Cartel and began using MultiPlan’s out-of-network claims repricing services in May 2015.

24. Defendant The Cigna Group (“Cigna”) is one of the largest health insurance companies in the United States. It is a corporation organized under the laws of the State of Delaware, with its principal place of business in Broomfield, Connecticut. Cigna is the parent company, or otherwise affiliated or related company, to various commercial health insurance plans and prescription drug plans that operate in the United States. Those plans issue insurance or provide administrative services concerning healthcare claims in the form of (1) fully insured commercial health insurance plans, (2) self-funded administrative service only health plans, (3) hybrid-funded health plans, (4) Medicare Advantage plans, and (5) Medicaid plans. Cigna is a member of the MultiPlan Cartel and began using MultiPlan’s out-of-network claims repricing services in 2015.

25. Defendant UnitedHealth Group Incorporated (“UnitedHealth”) is one of the largest health insurance companies in the United States. It is a Delaware corporation with a principal place of business in Minnetonka, Minnesota. UnitedHealth has two divisions: UnitedHealthcare, which provides health benefits plans, and Optum, which provides health services, including pharmacy benefit manager services.

UnitedHealth is a vertically integrated healthcare enterprise with a portfolio of wholly owned subsidiaries comprising a massive healthcare ecosystem. These subsidiaries include the largest commercial health insurance company in the United States, UnitedHealthcare. UnitedHealthcare has a commercial insurance network that pays in-network and out-of-network claims from healthcare providers in all 50 states and the District of Columbia. UnitedHealth's insurance plans issue insurance or provide administrative services concerning healthcare claims in the form of (1) fully insured commercial health insurance plans, (2) self-funded administrative service-only health plans, (3) hybrid-funded health plans, (4) Medicare Advantage plans, and (5) Medicaid plans. UnitedHealth is a member of the MultiPlan Cartel and began using MultiPlan's out-of-network claims repricing services in 2016.

26. Aetna, Cigna, and UnitedHealth are collectively referred to in this complaint as the "Insurer Defendants." They have each executed an out-of-network claims repricing services agreement with MultiPlan and have participated in the MultiPlan price-fixing Cartel. Each has performed acts and made statements in furtherance of the conspiracy. Accordingly, along with MultiPlan, the Insurer Defendants are jointly and severally liable for all the acts and omissions of their co-conspirators, whether named or not named in this complaint.

### III. CO-CONSPIRATORS

27. The named Defendants are not the only participants in the MultiPlan Cartel. MultiPlan sets out-of-network reimbursement rates for nearly all major health insurers in the United States, and many of the smaller ones. It has bragged that it contracts with some 700 health insurance companies and payers—including the 15 largest health insurers in the United States—to provide out-of-network claims repricing services.

28. The conspiracy alleged herein includes any person or entity that has entered into an out-of-network claims repricing services agreement with MultiPlan, used MultiPlan's out-of-network claims repricing tools to process claims for out-of-

1 network healthcare services, or otherwise participated with the Defendants in the  
2 alleged anticompetitive conspiracy and performed and made statements in furtherance  
3 of the conspiracy.

4 29. Defendants are jointly and severally liable for the acts of these co-  
5 conspirators, whether or not they are named as defendants in this complaint, including  
6 but not limited to:

7 30. Blue Shield of California Life & Health Insurance Company (“BSCA”) is a  
8 health insurance company. It is a California corporation with a principal place of  
9 business in California. BSCA is a licensee of the Blue Cross and Blue Shield  
10 Association and is license to offer Blue Cross and Blue Shield-branded health insurance  
11 plans in California. Those plans issue insurance or provide administrative services  
12 concerning healthcare claims in the form of (1) fully insured commercial health  
13 insurance plans, (2) self- funded administrative service only health plans, (3) hybrid-  
14 funded health plans, (4) Medicare Advantage plans, and (5) Medicaid plans. BSCA is a  
15 member of the MultiPlan Cartel. On information and belief, BSCA began using  
16 MultiPlan’s out-of-network claims repricing services around the same time as the other  
17 Insurer Defendants.

18 31. Blue Cross and Blue Shield of Florida, Inc. (“BCBSFL”) is a health  
19 insurance company. It is a Florida corporation with a principal place of business in  
20 Florida. BCBSFL is a licensee of the Blue Cross and Blue Shield Association and is  
21 license to offer Blue Cross and Blue Shield-branded health insurance plans in Florida.  
22 Those plans issue insurance or provide administrative services concerning healthcare  
23 claims in the form of (1) fully insured commercial health insurance plans, (2) self-  
24 funded administrative service only health plans, (3) hybrid-funded health plans, (4)  
25 Medicare Advantage plans, and (5) Medicaid plans. On information and belief, BCBSFL  
26 is a member of the MultiPlan Cartel.

27 32. Blue Cross Blue Shield of Michigan Mutual Insurance Company  
28 (“BCBSMI”) is a Michigan mutual insurance company. Its principal place of business is

1 in Michigan. BCBSMI is a licensee of the Blue Cross and Blue Shield Association and  
 2 is license to offer Blue Cross and Blue Shield-branded health insurance plans in  
 3 Michigan. Those plans issue insurance or provide administrative services concerning  
 4 healthcare claims in the form of (1) fully insured commercial health insurance plans, (2)  
 5 self-funded administrative service only health plans, (3) hybrid-funded health plans, (4)  
 6 Medicare Advantage plans, and (5) Medicaid plans. On information and belief, BCBSMI  
 7 is a member of the MultiPlan Cartel.

8       33. Centene Corporation (“Centene”) is one of the largest health insurance  
 9 companies in the United States. It is a Delaware corporation with its principal place of  
 10 business in St. Louis, Missouri. Centene is the parent company, or is otherwise affiliated  
 11 or related, to various commercial health insurance plans and prescription drug plans  
 12 operating in the United States. Those plans issue insurance or provide administrative  
 13 services concerning healthcare claims in the form of (1) fully insured commercial health  
 14 insurance plans, (2) self-funded administrative service only health plans, (3) hybrid-  
 15 funded health plans, (4) Medicare Advantage plans, and (5) Medicaid plans. On  
 16 information and belief, Centene is a member of the MultiPlan Cartel.

17       34. Elevance Health, Inc. (formerly known as Anthem, Inc.) (“Elevance”) is one  
 18 of the largest health insurance companies in the United States. Elevance is a member  
 19 of the Blue Cross and Blue Shield Association, a joint venture of insurance companies  
 20 that work together to offer their members access to a nationwide network of healthcare  
 21 providers. It is an Indiana corporation with a principal place of business in  
 22 Indianapolis, Indiana. Elevance licenses certain trademarks and service marks from  
 23 the Blue Cross and Blue Shield Association in 14 states: California, Colorado,  
 24 Connecticut, Georgia, Indiana, Kentucky, Maine, most of Missouri, Nevada, New  
 25 Hampshire, parts of New York, Ohio, Virginia (except the Washington, D.C. suburbs),  
 26 and Wisconsin. Elevance is the parent company, or otherwise affiliated or related  
 27 company, to various commercial health insurance plans and prescription drug plans  
 28 that operate in the United States. Those plans issue insurance or provide

1 administrative services concerning healthcare claims in the form of (1) fully insured  
2 commercial health insurance plans, (2) self-funded administrative service only health  
3 plans, (3) hybrid-funded health plans, (4) Medicare Advantage plans, and (5) Medicaid  
4 plans. On information and belief, Elevance is a member of the MultiPlan Cartel.

5 35. Health Alliance Medical Plans, Inc. (“Health Alliance”), a subsidiary of  
6 Carle Clinic Association, is a health insurance company. It is a corporation organized  
7 under the laws of Illinois with a principal place of business in Illinois. Health Alliance  
8 offers health insurance plans in Illinois, Iowa, Indiana, and Ohio, and its sister  
9 company, Health Alliance Northwest, offers health insurance plans in Washington.  
10 Those plans issue insurance or provide administrative services concerning healthcare  
11 claims in the form of (1) fully insured commercial health insurance plans, (2) self-  
12 funded administrative service only health plans, (3) hybrid-funded health plans, (4)  
13 Medicare Advantage plans, and (5) Medicaid plans. On information and belief, Health  
14 Alliance is a member of the MultiPlan Cartel.

15 36. Health Care Service Corporation, a Mutual Legal Reserve Company  
16 (“HCSC”) is one of the largest health insurance companies in the United States. It is  
17 organized as a mutual reserve company under the laws of the state of Illinois with a  
18 principal place of business in Chicago, Illinois. HCSC licenses certain trademarks and  
19 service marks of the Blue Cross and Blue Shield Association and does business in  
20 Illinois as Blue Cross and Blue Shield of Illinois. HCSC is the parent company, or is  
21 otherwise affiliated or related, to various commercial health insurance plans and  
22 prescription drug plans that operate in the United States, including in Illinois,  
23 Montana, New Mexico, Oklahoma, and Texas. Those plans issue insurance or provide  
24 administrative services concerning healthcare claims in the form of (1) fully insured  
25 commercial health insurance plans, (2) self-funded administrative service only health  
26 plans, (3) hybrid-funded health plans, (4) Medicare Advantage plans, and (5) Medicaid  
27 plans. On information and belief, HCSC is a member of the MultiPlan Cartel.  
28

37. Humana Inc. (“Humana”) is one of the largest health insurance companies in the United States. It is a Delaware corporation with its principal place of business in Louisville, Kentucky. Humana is the parent company, or otherwise affiliated or related company, to various commercial health insurance plans and prescription drug plans that operate in the United States. The plans issue insurance or provide administrative services concerning healthcare claims in the form of (1) fully insured commercial health insurance plans, (2) self-funded administrative service-only health plans, (3) hybrid-funded health plans, (4) Medicare Advantage plans, and (5) Medicaid plans. On information and belief, Humana is a member of the MultiPlan Cartel.

38. Kaiser Permanente LLC (“Kaiser”) is one of the largest U.S. health insurance companies in the United States. It is a California corporation with a principal place of business in Oakland, California. Kaiser is the parent company, or otherwise affiliated or related company, to many commercial health insurance and prescription drug plans that operate in the United States. The plans issue insurance in the form of (1) fully insured commercial health insurance plans; (2) self-funded administrative service only health plans; (3) Medicare Advantage plans; and (4) Medicaid plans. On information and belief, Kaiser is a member of the MultiPlan Cartel.

#### IV. JURISDICTION AND VENUE

39. This case arises under Section 1 of the Sherman Act (15 U.S.C. § 1) and Sections 4 and 16 of the Clayton Act (15 U.S.C. §§ 15 & 26). Plaintiff seeks treble damages for their injuries, and those suffered by members of the proposed Class, resulting from Defendants’ anticompetitive conduct; to enjoin Defendants’ anticompetitive conduct; and for such other relief as is afforded under the laws of the United States.

40. This Court has subject matter jurisdiction pursuant to 28 U.S.C. §1331 (federal question) and § 1337(a) (antitrust), and 15 U.S.C. § 15 (antitrust). This Court also has jurisdiction over this action pursuant to 28 U.S.C. § 1332(d) because this is a class action in which the aggregate amount in controversy exceeds \$5,000,000, exclusive

1 of interest and costs, and at least one member of the proposed Class is a citizen of a  
2 state different from that of each Defendant.

3 41. This Court has personal jurisdiction over MultiPlan because it transacts  
4 business throughout the United States, including in this district (including repricing  
5 claims for OON healthcare services performed in this district); and is engaging in the  
6 alleged antitrust conspiracy, which has a direct, foreseeable, and intended effect of  
7 causing injury to the business or property of persons and entities residing in, located in,  
8 or doing business throughout the United States, including in this district.

9 42. This Court has personal jurisdiction over the Insurer Defendants because  
10 each of them transacts business throughout the United States, including in this district  
11 (including providing reimbursements for OON claims for healthcare services performed  
12 in this district), and engages in the alleged antitrust conspiracy, which has a direct,  
13 foreseeable, and intended effect of causing injury to the business or property of persons  
14 and entities residing in, located in, or doing business throughout the United States,  
15 including in this district.

16 43. Venue is proper in this district pursuant to Section 12 of the Clayton Act,  
17 15 U.S.C. § 22, and under the federal venue statute, 28 U.S.C. § 1391, because certain  
18 unlawful acts by the Defendants were performed in this district, and those and other  
19 unlawful acts caused harm to interstate commerce in this district. No other forum  
20 would be more convenient for the parties and witnesses to litigate this case.

## 21 V. DIVISIONAL ASSIGNMENT

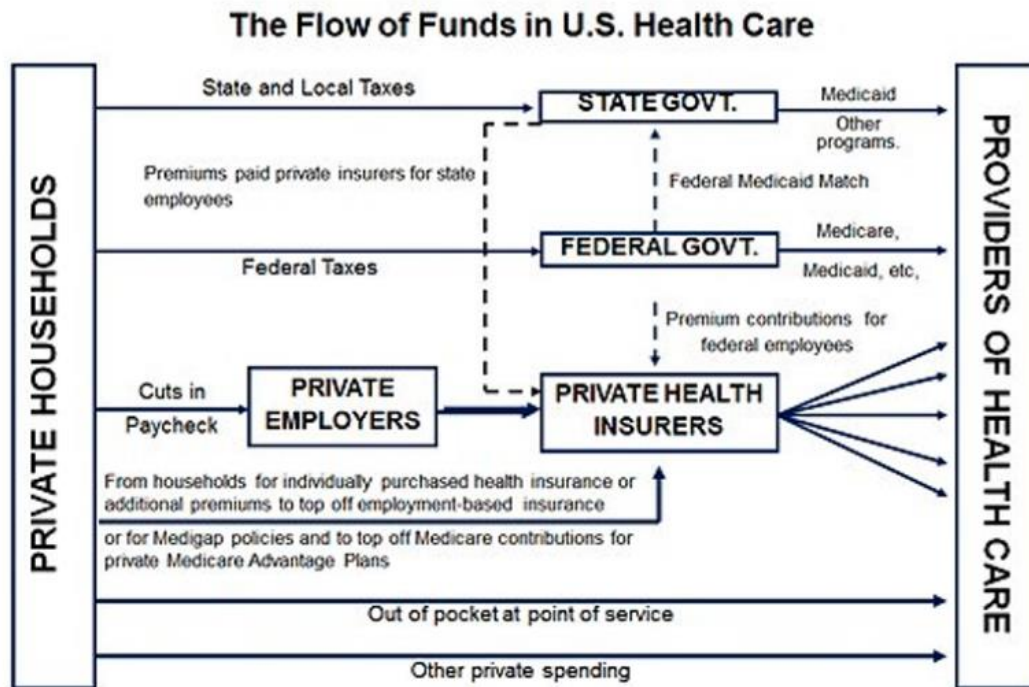
22 44. Pursuant to Civil Local Rule 3-2(d), this case should be assigned to the San  
23 Francisco Division because a substantial part of the events or omissions giving rise to  
24 the claim occurred within the County of Marin.

## VI. FACTUAL BACKGROUND

### A. The Out-of-Network Healthcare Services Industry.

#### 1. Third-Party Payers and their Provider Networks.

45. Roughly 90 percent of U.S. healthcare expenses—including those related to out-of-network care—are paid for not by patients themselves, but by an assortment of public and private third-party payers (“TPPs”), often referred to as “insurers.” Third-party payers include government-funded insurance programs (like Medicare and Medicaid); self-insured employers (whose plans are typically administered by commercial insurance companies); and commercial insurance companies themselves (such as UnitedHealthcare, Anthem, Aetna, Humana, Cigna, and the various Blue Cross/Blue Shield companies).



Source: Reinhardt UE. *The Money Flow From Household to Health Care Providers* (2011)<sup>4</sup>

46. Most healthcare providers depend upon reimbursements from insurers to stay in business. Typically, providers collect only nominal amounts from patients at the point of service (usually in the form of “copays” or “co-insurance”). They then submit the bill (or “claim”) for services rendered to the patient’s insurer to obtain payment.

1           47. All medical claims submitted to insurance use the same set of uniform  
2 billing codes. Procedure code sets like CPT (“Current Procedure Terminology”) and  
3 ICD-10-PCS (“International Classification of Diseases, 10th Revision, Procedure Coding  
4 System”) tell the payer *which* service the provider performed. Diagnosis codes sets like  
5 the ICD-10-CM (“International Classification of Diseases, 10th Revision, Clinical  
6 Modification”) tell the payer *why* the patient received the service. Most claims contain  
7 numerous codes, reflecting each diagnosis and treatment administered during a medical  
8 visit. Typically, providers receive reimbursement for each code billed (so long as it is  
9 covered by the patient’s healthcare plan).

10           48. Healthcare providers often employ administrative professionals called  
11 “billers” and “coders” to extract billing information from patients’ medical charts,  
12 generate the claims that are submitted to insurance, and ensure that the proper  
13 reimbursement amounts are received. Many providers also employ third-party  
14 clearinghouses to pre-screen claims, correct errors, and securely transmit them to  
15 insurers (and patients).

16           49. Insurers seek to predict and, if possible, limit the prices they will pay for  
17 medical services. To that end, most insurers maintain “networks” of healthcare  
18 providers who have agreed to offer one or more insurers discounted rates for services in  
19 exchange for (a) access to their subscribers (often called “patient steerage”) and  
20 (b) the avoidance of certain administrative burdens associated with negotiating the cost  
21 of services with insurers on an ad hoc basis.

22           50. Network agreements between providers and insurers typically detail the  
23 kinds of services to be covered by the insurer, the amount the provider will be  
24 reimbursed for each covered service, and the process by which claims for  
25 reimbursement are adjudicated.

26           51. Network agreements contain proprietary, competitively sensitive terms,  
27 including agreed-upon rates that result from closed-door negotiations between insurers  
28

1 and providers.<sup>1</sup> Insurers seek to protect the rates and other information in their  
2 network agreements from disclosure. They know that competing insurance companies  
3 may use the information to lure providers to their networks by offering superior terms  
4 (which in turn drives up in-network rates for the industry); they also know that  
5 healthcare providers may leverage the information to demand more favorable rates  
6 during future negotiations. Moreover, public disclosure of negotiated rates can lead to  
7 subscriber backlash if negotiated discounts do not result in lower plan premiums.  
8 Given these sensitivities, the industry has taken the position that agreed-upon rates  
9 under in-network agreements are trade secrets.

10       52. The in-network rates insurers offer providers—even for the same  
11 services—vary widely. Hospitals, with their extensive service offerings and substantial  
12 market presence, typically command higher reimbursement rates from insurance  
13 companies, whereas independent practices, due to their smaller size and limited  
14 bargaining power, typically secure far less favorable in-network rates. In many cases,  
15 the in-network rates offered fall below the operational costs incurred by providers: as  
16 one recent study by the American Medical Group Association reports, the median loss  
17 for medical groups was \$249,000 per physician. A provider in this situation is then  
18 faced with a difficult decision: They can accept inadequate in-network rates, knowing  
19 that doing so may leave them in financial extremis. Or they can decline to join some or  
20 all insurance networks (knowing it will result in the loss of patient volume), which  
21 allows them to bill patients' insurance plans (assuming those plans have out-of-network  
22 benefits) at the prevailing market rate.

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23  
24  
25  
26 <sup>1</sup> Prior to 2022, in-network rates were virtually always treated confidential and  
27 proprietary. In 2022, federal legislation went into effect requiring insurers to disclose  
28 the terms of certain network agreements with hospital. Transparency in Coverage, 85  
Fed. Reg. 72158 (Nov. 12, 2020) (to be codified at 26 C.F.R. pt. 54; 29 C.F.R. pt. 2590; 45  
C.F.R. pt. 147; and 45 C.F.R. pt. 158).

1                   **2. Out-of-Network Care**

2           53. Many providers refrain from participating in network arrangements for  
3 one, some, or all insurers. Some providers determine that the in-network rates offered  
4 by insurers are too low (which is often the case for independent practices), or that the  
5 network will not provide them with adequate patient volume to justify the requested  
6 discounts. Other providers refuse to join certain networks because of the  
7 administrative burden and expense associated with obtaining in-network  
8 reimbursement.

9           54. Claims submitted to an insurer for healthcare services covered by a  
10 network agreement are called “in-network” or “contracted” claims. Claims for services  
11 not covered by a network agreement are called “out-of-network,” “non-contracted,” or  
12 “retail” claims.

13           55. The ability of providers to submit out-of-network claims in this way, obtain  
14 fair reimbursements for them, and profitably practice medicine outside of insurance  
15 networks represents a powerful form of leverage on the side of providers in negotiating  
16 in-network rates. It functions, essentially, as a check on insurers’ ability to drive in-  
17 network rates too low. However, as described herein, the MultiPlan Cartel drastically  
18 reduces providers’ leverage in this regard by suppressing out-of-network  
19 reimbursement rates far below competitive levels, such that the threat of any provider  
20 going out-of-network becomes increasingly hollow. This, in turn, indirectly suppresses  
21 in-network rates as well.

22                   **3. Claims Reimbursement.**

23           56. The reimbursement process for in-network claims is relatively  
24 straightforward. Once the insurer receives a claim from an in-network provider, the  
25 claim enters the adjudication process, during which the claim will either be “accepted”  
26 (meaning paid), “denied” (not paid), or “rejected” (returned due to error). If some but  
27 not all of the services reflected in the bill are covered by the insurer’s plan, the insurer  
28 may approve the covered costs while rejecting the non-covered costs.

57. Following adjudication, the insurer submits a report to the provider detailing which codes it is willing reimburse and at what rate (according to parties' network agreement). The provider then checks the report for accuracy and may begin an appeals process (the procedure for which is governed by the network agreement) should a dispute arise.

58. In contrast, when a provider is out-of-network, there is no contract between the insurer and the provider to govern the parties' obligations to one another, how claims are adjudicated, or the means for resolving any disputes over such claims. Nor is there an obligation on the part of the provider to render out-of-network services to an insurer's members, with certain limited exceptions (like emergency care). In the absence of such an agreement, the insurer and provider are left to negotiate what services will be paid for, and in what amount, on the free market.

#### 4. Unlike HMOs, PPOs Offer Out-of-Network Coverage.

59. Not all insurance plans cover out-of-network services, and those that do are typically priced at a premium. The two most common of forms of health insurance in the United States are health maintenance organizations ("HMOs") and preferred provider organizations ("PPOs"). Both employ provider networks to manage costs. However, HMOs require patients to obtain healthcare services only from providers that participate in the plan network, and who have agreed to offer steeply discounted prices to plan members.<sup>2</sup> PPOs, by contrast, give patients a choice: They can either obtain care from a cost-effective in-network provider (and receive the maximum reimbursement from the insurer under their plan) or they can get care from an out-of-network provider of their choosing (and receive a reduced though still significant reimbursement amount).

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<sup>2</sup> An HMO plan may, at times, provide partial reimbursement for services performed by a healthcare provider not within network, but only in extraordinary circumstances. Such coverage typically requires prior authorization by the insurer, which will pre-negotiate the terms of reimbursement with the provider.

1           60. Under most PPO plans, insurers agree to pay a large, fixed percentage  
2 (typically 80-90 percent) of the expected charge of out-of-network care, which insurers  
3 typically refer to as the “usual, customary, and reasonable” (or “UCR”) rate, less the  
4 patient’s cost-share contribution. The UCR rate, as described further below, is  
5 supposed to be fair reflection of the market rate for a given service in a particular  
6 geographic area.

7           61. Because the insurer does not have a contract with the out-of-network  
8 provider, the consumer is financially responsible for paying the balance of the bill (*i.e.*,  
9 the portion of the bill the insurance company does not pay). And the provider may, as a  
10 matter of law (with some limited exceptions), pursue the remainder of its charge from  
11 the consumer, regardless of how little or how much the insurer reimburses the  
12 consumer.<sup>3</sup>

13           62. The option to see out-of-network health insurance providers comes at a  
14 cost to subscribers. PPO premiums (and deductibles) are significantly higher on  
15 average than those for HMOs. For example, for a 30-year-old, the average PPO plan  
16 established under the Affordable Care Act costs about \$800 more per year than the  
17 average HMO plan. Nevertheless, PPOs are the most common plan type in the United  
18 States, with nearly half of all insured U.S. employees covered by a PPO, reflecting  
19 payers’ and patients’ preference for increased provider choice.

20           63. There are many reasons consumers may choose to pay higher premiums  
21 and deductibles for the option of seeing out-of-network providers. After changing  
22 employers, a person may wish to continue working with certain providers, like a long-  
23 standing primary care physician, even if those providers no longer participate in the  
24 insured’s new healthcare plan. Other patients know that they have a medical condition  
25

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26 <sup>3</sup> Recent legislation has placed prohibitions on balance billing for emergency care and  
27 for certain out-of-network care performed at an in-network facility. *See* Requirements  
28 Related to Surprise Billing, 87 Fed. Reg. 52618 (Aug. 26, 2022) (to be codified at 26  
C.F.R pt. 54; 29 C.F.R. pt. 2590; and 45 C.F.R. pt. 149).

1 that requires specialized treatment that may only be available from out-of-network  
2 providers. Geography is also a factor, as convenient in-network options are often  
3 limited for those who travel frequently or who live in rural areas. And many consumers  
4 wish to protect themselves financially in the event of a new diagnosis or emergency,  
5 when obtaining in-network care may be impossible or inferior to other options.

6 64. And insurers understand why out-of-network coverage appeals to U.S.  
7 consumers. That's why they market PPOs with labels like "freedom" and "choice." Yet,  
8 behind the scenes, they do everything possible to under-reimburse the out-of-network  
9 providers who make PPO plans desirable in the first place.

#### 10 5. Competition Among PPOs for Out-of-Network Providers

11 65. In a competitive market, insurers that sell plans with out-of-network  
12 benefits are incentivized to ensure that plan subscribers can obtain services from out-of-  
13 network providers. To do so, insurers must, at a minimum, pay out-of-network  
14 providers competitive reimbursement rates.

15 66. Insurers know that a provider who receives below-market reimbursement  
16 amounts for out-of-network care may, in response, refuse to serve their members in the  
17 future, or elect to balance bill those patients for the uncovered portions of their out-of-  
18 network claims. When this occurs, subscribers are harmed financially, and may decide  
19 that their plans' out-of-network benefits are overpriced (or even illusory). This may  
20 lead them to switch to a competing PPO. The industry often refers to this as member  
21 and provider "abrasion."

22 67. Given the risk of such "abrasion," under normal market conditions (*i.e.*,  
23 absent a market restraint), it would be economically irrational for an individual insurer  
24 to lowball out-of-network providers with below-market reimbursements. Insurers  
25 would instead compete against each other for out-of-network provider services to keep  
26 their current PPO subscribers happy (and obtain new ones), including by offering  
27 competitive reimbursement rates on out-of-network claims.  
28

68. But as set forth in further detail below, such competition has been largely eliminated by the MultiPlan Cartel. Insurers now act collectively, though MultiPlan, to slash out-of-network reimbursement rates. Absent an assurance that their competitors are doing the same thing, individual insurers would not lowball out-of-network providers in this way for fear of creating subscriber and provider abrasion. The MultiPlan Cartel provides them with that assurance.

## **B. Historical Pricing of Out-of-Network Provider Services.**

### **1. Usual and Customary Rates (“UCR”)**

69. Historically, normal competitive pressures (along with inflation and other factors) tended to drive up the price of out-of-network care over time. But the insurance industry had a system in place to ensure that they would not be on the hook for excessive provider pricing: UCR.

70. For decades, and until the late 1990s, health insurers based out-of-network reimbursements on statistical benchmarks for medical costs based on prevailing market rates, *i.e.*, the retail prices charged by doctors in particular geographic areas. These benchmarks are collectively referred to as the “usual, customary, and reasonable” (“UCR”) rates, or sometimes just “reasonable and customary” rates (“R&C”).

71. Historically, UCR rates were calculated using data from two databases: the Prevailing Healthcare Charges System (“PHCS”) and Medical Data Resource (“MDR”). PHCS was created in 1973. Until the late 1990s, it was run by then the then-insurance industry trade organization, Health Insurance Association of America (“HIAA”).<sup>4</sup> MDR was created in 1987; until the late 1990s, it was run by Medicode.

72. Insurers and providers have always understood that the UCR rate refers to the “the prevailing rate doctors charge when they have not negotiated a lower rate

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<sup>4</sup> HIAA later merged with another industry trade association, the American Association of Health Plans (“AAHP”) to form America’s Health Insurance Plans (“AHIP”), of which the executives of many of the Insurer Defendants and co-conspirators in this case are high-ranking board members.

1 with the insurer on an in-network basis.”<sup>5</sup> That’s because when a doctor (or other  
 2 professional) provides services on an out-of-network basis, they do not receive the  
 3 promise of increased patient volume and other benefits (like prompt and predictable  
 4 payment) that come with contracting to participate in an insurer’s network. In the  
 5 absence of increased volume or other contractual inducements, providers would not  
 6 offer discounts to payers, and payers would not expect to pay substantially less than the  
 7 retail charge amount. Therefore, pre-negotiated, discounted, in-network rates do not  
 8 and have never represented reasonable rates of reimbursement for out-of-network  
 9 claims, and have never been relevant to the proper calculation of UCR rates.

10 73. Accordingly, to properly calculate UCR rates, insurers historically used  
 11 aggregated, retail medical charge data (not reimbursement or payment data) for like  
 12 healthcare services performed in the same geographic markets. Based on this  
 13 aggregated charge data, each insurer exercised its own independent judgment to  
 14 determine the applicable UCR rate for a particular medical service (often referred to as  
 15 the “allowed amount” by insurers). Each insurer then exercised its own independent  
 16 judgement to determine what proportion of the UCR rate to cover for plan subscribers,  
 17 which the insurer included in its plan documents to notify subscribers.

18 74. Historically, many insurers employed the 80th percentile rule to calculate  
 19 UCR rates. This method is based on the distribution of charges for similar medical  
 20 services within a specific geographic area; it pegs the UCR rate to the charge amount  
 21 below which 80% of all submitted charges fall. For example, if, after analysis, the 80th  
 22 percentile charge for a colonoscopy in a particular geographic area is identified as  
 23 \$1,200, this figure becomes the UCR rate for that service in that market. This approach  
 24 aims to ensure that UCR rates reflect prevailing market rates (covering the majority of  
 25 charges up to the 80th percentile), while eliminating higher outlier charges.

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26  
 27 <sup>5</sup> *Deceptive Health Insurance Industry Practice: Are Consumers Getting What They Paid*  
 28 *For?* (Part I): S. Hr’g. 111-37 Before S. Comm. on Commerce, Science, &  
 Transportation, 111th Cong. 5 (2009).

75. Determining UCR rates in this way does not mean that insurers pay providers the entire UCR rate. Instead, insurers would typically cap reimbursement at 80-90% of the UCR rate and require that the subscriber to pay the remainder as co-insurance. For example, an insurer that promised plan members that it would reimburse out-of-network claims at 80% of the UCR rate would pay the lower of the actual billed charge or 80% of the UCR rate for similar procedures in the same geographic area; the patient would then contribute the remaining 20% of the UCR rate as co-insurance. The obligations of both insurers and patients were thus pegged to the UCR rate.

76. A hypothetical example of how reimbursement would be calculated under this method is as follows: A physician submits a \$1,350 bill for a colonoscopy for a patient who has a PPO insurance plan with out-of-network benefits that (a) follows the 80th percentile rule to set UCR rates and (b) caps the allowed amount for out-of-network claims at 80% of the UCR rate. The insurer accesses data from a UCR database for other colonoscopies performed in the same geographic location. The data shows there were 10 other colonoscopies performed in that region, which were billed at \$500, \$600, \$700, \$800, \$900, \$1,000, \$1,100, \$1,200, \$1,300, and \$1,400. These charges are then organized from lowest to highest to determine percentiles:

Procedure	Percentile							
	20 <sup>th</sup>	30 <sup>th</sup>	40 <sup>th</sup>	50 <sup>th</sup>	60 <sup>th</sup>	70 <sup>th</sup>	80 <sup>th</sup>	90 <sup>th</sup>
Colonoscopy	\$600	\$700	\$800	\$900	\$1,000	\$1,100	\$1,200	\$1,300

77. At the 50th percentile, half of the charges recorded in the database are lower, and half are higher. At the 70th percentile, 70% of recorded charges are lower, and 30% are higher. In this hypothetical, because the insurer uses the 80th percentile rule to calculate UCR rates, the UCR rate for colonoscopies in this geographical area is \$1,200. As such, the plan would reduce the physician's billed charge from \$1,350 to \$1,200. Then, the insurer would pay 80% of that amount, or \$960. The patient is then obligated to pay the remaining 20% of that \$1,200 charge, or \$240, as co-insurance.

1           78. Once a healthcare provider receives notice from an insurer of the allowed  
2 amount of a claim, that provider has the option of seeking additional reimbursement  
3 from the patient for the amount of the charged bill above the allowed amount. This is  
4 known as “balance billing.” Using the above hypothetical again as an example, the  
5 doctor could bill the patient for the \$150 difference between its charged claim (\$1,350)  
6 and the allowed amount (\$1,200).

7           79. The UCR system represented a means of normalizing healthcare costs. As  
8 William Marino, former President and CEO of Horizon Blue Cross Blue Shield of New  
9 Jersey, explained to the U.S. Senate Committee on Commerce, Science and Technology  
10 in 2009, UCR was “designed to permit payment amounts that would be predictable,  
11 change with market-based changes in prevailing payments, and keep insurance costs in  
12 check by eliminating excessive charges from the insurance pool.”

13           80. In other words, UCR gave the insurance industry a means of combatting  
14 what some insurers claimed were excessive charges for medical care, while still  
15 adequately compensating providers. Despite having a means to control costs in a fair  
16 and reasonable way, insurers have, at various points, resorted to anticompetitive tactics  
17 to further reduce out-of-network costs.

## 18                   **2. Prior Industry Collusion: The Ingenix Cartel (1997-2009)**

19           81. In many ways, the MultiPlan Cartel is the modern-day incarnation of a  
20 prior collusive effort by insurers to suppress out-of-network reimbursement rates: the  
21 Ingenix Cartel.

22           82. Between 1997 and 1998, a UnitedHealth Group subsidiary called Ingenix  
23 purchased the two then-existing claims databases used for the calculation of UCR:  
24 MDR and PHCS. It then consolidated those databases in 2001. With UnitedHealth’s  
25 acquisition of all UCR claims databases, one of the largest insurance companies in the  
26 nation became functionally responsible for the way the entire industry would be setting  
27 UCR rates (and, in turn, nationwide reimbursement levels for out-of-network claims).  
28

1           83. Allowing an insurance company to control the nation's sole UCR database  
2 was a massive conflict of interest. Ingenix was incentivized to skew its aggregate  
3 claims data downwards in order to reduce apparent UCR rates—and that is precisely  
4 what it did. Every dollar saved on out-of-network reimbursements based on Ingenix's  
5 claims data represented increased profits for UnitedHealth, as well as for its rivals in  
6 the insurance industry.

7           84. For more than a decade after UnitedHealth's acquisition of the nation's  
8 UCR data infrastructure, the health insurance industry overwhelmingly used Ingenix  
9 data to set reimbursement rates for out-of-network claims. But in the late 2000s,  
10 providers and consumers began to complain about uncharacteristically low out-of-  
11 network claims reimbursement rates, which resulted in doctors balance billing patients  
12 for huge sums. These complaints spurred several investigations and lawsuits over  
13 Ingenix's practices, which eventually revealed that Ingenix was systematically  
14 manipulating its data with the purpose and effect of reducing apparent UCR rates.

15           85. Ingenix achieved this effect in several ways. First, Ingenix commingled  
16 charge data on claims submitted under network agreements (which reflected discounted  
17 in-network rates) with data reflecting out-of-network retail charges. As noted above, in-  
18 network rates do not represent reasonable rates of reimbursement for out-of-network  
19 claims because when a provider performs services on an out-of-network basis, it does  
20 not receive any of the contractual benefits associated with network participation (*i.e.*,  
21 increased patient volume). By improperly including heavily discounted in-network  
22 charges in its claims database, Ingenix systematically and artificially depressed the  
23 apparent prevailing market rates for services, and, in turn, the calculation of UCR  
24 rates.

25           86. Second, Ingenix removed higher-end claims from its databases using  
26 formulaic edits to identify and purge roughly 5% of all submitted charges without first  
27 investigating whether the charge information was incorrect. Insurance companies that  
28 contributed data to the Ingenix database did the same. For example, Aetna, which was

1 Ingenix's single largest data contributor, "pre-scrubbed" its data before submitting it,  
2 eliminating the highest 20% of valid medical charges before sending claims data to  
3 Ingenix.

4 87. Such data manipulation made the distribution of medical charges in  
5 Ingenix's UCR databases appear 10-28% lower than they really were. Any out-of-  
6 network claim reimbursement calculations performed using Ingenix's data thus skewed  
7 10-28% lower, resulting in underpayments to health care providers and exposing  
8 patents to the risk of balance billing.

9 88. Whenever an insurer or Ingenix received an inquiry from a doctor or  
10 patient regarding how UCR rates were calculated, they responded, "it's proprietary."  
11 Meanwhile, Ingenix did not even attempt to maintain that its UCR data was accurate.  
12 As an Ingenix employee testified under oath:

13 *Ingenix has never tested its results* to determine if its statistical  
14 conclusions bear any relationship to the actual high, low,  
15 median or 80th percentile . . . rates charged by health care  
providers in any given area.

16 89. As Ingenix and UnitedHealth would later be forced to admit, Ingenix's  
17 close ties with the industry—and its status as a UnitedHealth subsidiary—created  
18 "inherent" conflicts of interest.

19 90. Several lawsuits were filed against insurers by physicians who were  
20 underpaid and by patients who were balance billed as a result of Ingenix's UCR  
21 database manipulation. In 2000, the American Medical Association ("AMA") and  
22 several state-specific medical associations filed a class action against UnitedHealth  
23 alleging that Ingenix improperly reduced out-of-network reimbursements to healthcare  
24 providers in violation of the Racketeer Influenced and Corrupt Organizations Act  
25 ("RICO") and the antitrust laws. The suit settled in 2009, with UnitedHealth agreeing  
26 to pay \$350 million to class members.

1                   **3. FAIR Health, Inc.**

2           91. In February 2008, then-New York Attorney General Andrew Cuomo  
3 announced an investigation “into a scheme by health insurers to defraud consumers by  
4 manipulating reimbursement rates.” Linda Lacewell, the assistant attorney general in  
5 charge of that investigation, described Ingenix as “essentially a closed-loop system of  
6 the health insurance industry collecting the information among itself, pooling the  
7 information together, all relying on the same information, a system that is  
8 impenetrable to the consumer.” The investigation found, for example, that “[o]ne  
9 national insurer filled an entire page with a list of alternative ways in which it  
10 purported to calculate out-of-network rates, in language that can best be described as  
11 gobbledygook” when, in reality, it simply “pa[id] the same rates for in-network and out-  
12 of-network care.”

13           92. The NYAG investigation culminated in the demise of Ingenix. In January  
14 2009, a settlement was announced between NYAG and UnitedHealth; as part of the  
15 deal, UnitedHealth agreed to shut down Ingenix and contribute \$50 million to the  
16 formation of a new, independent non-profit organization, FAIR Health, Inc. (“FAIR”), to  
17 take ownership of the Ingenix UCR database. UnitedHealth further agreed to use  
18 FAIR for determining out-of-network reimbursement rates for at least five years, and to  
19 refrain from using, owning, operating, or funding any other database for such purpose  
20 during that time.

21           93. Similar settlements quickly followed for the other major insurers. Aetna  
22 agreed to pay \$20 million for the creation of FAIR, to contribute untainted data to the  
23 new database, and to use FAIR for five years. Cigna and WellPoint, Inc. (later known  
24 as Anthem, and then Elevance) agreed to pay \$10 million and to use FAIR for five  
25 years. Other smaller insurers reached settlement agreements that required them to  
26 contribute between \$200,000 and \$1.6 million and to use FAIR for five years.

27           94. FAIR was incorporated in October 2009, and became available for use in  
28 mid-2010. Under the terms of its NYAG settlement, UnitedHealth was required to shut

1 down the Ingenix database within 60 days of the date on which FAIR became available  
2 for use. Moreover, UnitedHealth and all other settling insurers were required to begin  
3 using FAIR within 60 days of the date on which it became operational, and to use it  
4 exclusively for the setting of out-of-network reimbursement rates for a period of at least  
5 five years. As FAIR became operational sometime in 2010, the obligation of the settling  
6 insurers (including the Insurer Defendants) to use FAIR expired sometime in 2015 or  
7 early 2016.

8       95. Once UnitedHealth shut down Ingenix, all insurers that had previously  
9 used Ingenix (not just those that had settled with NYAG) had to switch to a different  
10 data source. Because UnitedHealth had purchased and consolidated the only two  
11 databases available a decade earlier (leaving no privately controlled alternatives in the  
12 marketplace), FAIR was the obvious and near-universal choice.

13       96. FAIR began the gradual process of correcting the skewed UCR database it  
14 inherited from UnitedHealth. As FAIR collected more non-manipulated data from  
15 insurers (who were required by their settlement agreements to submit accurate, un-  
16 scrubbed charge data), the effects of the decades' long scheme to deflate reimbursement  
17 rates began to subside.

18       97. Over the next seven years, UCR rates rose some 26%. Half of that  
19 increase was attributable to cost-of-living increases during that time, but the remainder  
20 reflected the normalization of the UCR database and a return to a dataset that  
21 accurately reflected prevailing market rates free from manipulation. As a result,  
22 patients and physicians received more accurate and fair reimbursements from insurers  
23 for the medical care they received or provided. But it did not last.

24       **C. Insurers Abandon UCR-Based Claims Pricing in Favor of**  
25       **MultiPlan.**

26       98. Unsurprisingly, insurers were not happy with the free market dynamics of  
27 the UCR system, particularly when they could no longer manipulate UCR downward  
28 through Ingenix. Once the NYAG settlement agreements began to expire, insurers

sought to eliminate UCR entirely, and to replace it with a different methodology that would systematically suppress out-of-network reimbursement rates. Describing the post-Ingenix world, one MultiPlan executive has explained, “there was a need in the marketplace back in early 2010 . . . to really address what was a feasible allowable [reimbursement amount] in the marketplace on a professional side, to recommend as a payment [for providers].”

99. Around this time, many insurance executives expressed a desire to use Medicare rates, which are incredibly low, as the new benchmark for setting out-of-network reimbursement levels. However, these executives understood that absent collusion, using “barebones” Medicare rates as the benchmark would lead to balance billing, create massive member and provider abrasion, and was therefore untenable; in other words, the major insurers would have to undertake such a shift together to ensure its success. MultiPlan would emerge on the scene at precisely this time to offer a vehicle for collusion.

100. Indeed, the expiration of NYAG settlements opened the door for MultiPlan to become the new “independent” claims repricing service for the insurance industry. And almost immediately after insurers’ obligations to use FAIR expired under their agreements with NYAG, the industry abandoned FAIR—and UCR as the primary metric for determining out-of-network reimbursement rates—and instead began using MultiPlan’s claims repricing services.

101. A partial timeline of the 2015-2016 shift from FAIR to MultiPlan is below:

- (a) Cigna began using FAIR in 2010. In 2015, it completed its five-year obligation to use FAIR. In 2015, it contracted with MultiPlan to use its claims repricing services.
- (b) Aetna began using FAIR in 2010. In 2015, it completed its five-year obligation to use FAIR. On May 1, 2015, Aetna contracted with MultiPlan to use its claims repricing services.
- (c) UnitedHealth shut down its Ingenix database and began using FAIR by 2011. In 2016, it completed its five-year

obligation to use FAIR Health. And as UnitedHealth executives have testified, in 2016 UnitedHealth contracted with MultiPlan to use its claims repricing services for parts of its business, and further expanded such use in 2017.

(d) Other insurers also began using MultiPlan to reprice their out-of-network claims around the same time.

102. The industry's adoption of MultiPlan's claims repricing methodology was rapid, coinciding with the end of the major insurers' five-year commitments to use FAIR. This represented a complex and historically unprecedented change in insurers' out-of-network claims pricing structure, which had, for decades, been based on prevailing (or "usual and customary") market rates for services. Such rapid and concerted industry-wide change in pricing practices was a telltale sign of collusion, and an understanding amongst major insurers that they all had to undertake the shift together to ensure its success.

#### **D. The Evolution of MultiPlan's Business.**

##### **1. MultiPlan 1.0**

103. MultiPlan was not always in the claims repricing business. In fact, the company was founded in 1980 as a New York-based hospital network. Over time, MultiPlan expanded its provider and facility footprint. Today, it maintains a nationwide PPO network of over 1.3 million providers, which insurers can "rent" to decrease the number of claims that fall out-of-network. MultiPlan refers to its PPO network business as "MultiPlan 1.0."

104. To build and maintain its massive PPO network, MultiPlan negotiates with providers and facilities across the country to "establish discounts" for payers "in exchange for patient steerage [to participating providers] and other provider-friendly terms and conditions." MultiPlan then rents out its network to insurers, who, for a fee, get the benefit of the network discounts MultiPlan has negotiated. Insurers can use the MultiPlan PPO as either their primary provider network, or, in the case of larger insurers, to supplement or geographically extend their own preexisting networks. The

1 terms of MultiPlan’s rental arrangements with insurers are set forth in its standard  
2 “Network Rental Agreement.”

3 105. The value of MultiPlan’s network—and amount of rent MultiPlan can  
4 extract from insurers—is directly tied to the number of providers MultiPlan can  
5 convince to participate. The more providers MultiPlan signs up around the country, the  
6 more attractive its rental network becomes to potential insurer clients, and, in turn, the  
7 more MultiPlan can charge for access. For this reason, MultiPlan touts the  
8 participation of 1.3 million plus providers in its network as its major “competitive  
9 advantage.”

10 106. To attract providers to its network, MultiPlan must offer competitive  
11 reimbursements rates (and other inducements, such as patient steerage). If MultiPlan  
12 offers rates (or other terms) that are inferior to what competitor networks offer, it will  
13 lose the battle for providers.

14 107. In this race for providers, MultiPlan competes against insurers that offer  
15 PPO plans and operate their own networks. Many, if not most, of these insurers,  
16 including all of the Insurer Defendants, also hire MultiPlan to perform out-of-network  
17 claims repricing services (as detailed further below). As MultiPlan states in its public  
18 filings, MultiPlan “compete[s] with regional PPOs targeting primary network business,”  
19 and “with PPO networks *owned by [its] large Payor customers.*” In other words,  
20 MultiPlan and the insurers are horizontal competitors when it comes to PPO provider  
21 coverage, and in the markets for provider services. The same horizontal competitors  
22 then collude to fix the manner in which providers are paid for their services.

23 108. MultiPlan induces healthcare providers to join its PPO network—and to  
24 obligate themselves to provide services to patients insured by MultiPlan’s payer  
25 clients—with the promise of sky-high reimbursement rates. MultiPlan’s standard  
26 “Participating Provider Agreement” outlines certain “Contract Rates” which are “equal  
27 to eighty (80%) percent” of the provider’s “[b]ill charges . . . .” The rates specified in  
28

1 most standard network agreements are, by contrast, pegged to Medicare rates, and are  
2 far lower.

3 109. But this promise is illusory. Unlike bona fide network agreements, which  
4 contractually obligate insurers to pay specific amounts to doctors for performing covered  
5 services, MultiPlan's Provider Participation Agreement includes no payment obligation  
6 whatsoever on the part of any payer. Instead, it provides that MultiPlan may, "in its  
7 sole discretion," rent out its network to insurer clients who may choose *not* to pay the  
8 specified "Contract Rates" and instead opt to reimburse the provider based on the "out-  
9 of-Network benefit level" specified in the patient's PPO plan. Specifically, these  
10 agreements state:

11 [MultiPlan] may, in its sole discretion, include Group and each  
12 Participating Professional as a Network Provider in any or all  
13 Network(s). Group and each Participating Professional  
14 acknowledge that certain Programs offered by [payer] Clients  
15 accessing the Network (i) may not include a network option; or  
16 (ii) **may cover Covered Services under the Participant's  
Program at . . . out-of-Network benefit level.**"

17 110. MultiPlan knows (but does not disclose to providers) that many, if not  
18 most, of the claims submitted by participating providers will be reimbursed not at the  
19 specified Contract Rates. Instead, these claims will be treated by insurers as out-of-  
20 network claims and reimbursed at outrageously low levels that MultiPlan itself sets via  
21 its "Data iSight" OON claims repricing methodology (which is at the heart of the  
22 conspiracy alleged herein).

23 111. In fact, MultiPlan ensures as much. Its standard Network Rental  
24 Agreement with insurers essentially allows payers to reimburse MultiPlan network  
25 providers however they see fit. It provides that the insurer may "pay claims from  
26 [providers who participate in MultiPlan's PPO network] in accordance with a Member's  
27 [*i.e.*, the patient's] plan of benefits (*e.g.*, benefit plans providing benefit levels at  
28 Reasonable and Customary, percentage of Medicare, **or otherwise**) **in lieu of** the

1 Contract Rates MultiPlan dangles in front of providers to induce their participation in  
2 the MultiPlan network.

3 112. Given this reality, MultiPlan’s participation agreements with providers  
4 may be void for lack of consideration, with providers agreeing to perform services for  
5 various insurance plan subscribers with no guarantee of payment. Whether or not this  
6 is true, a claim submitted by a MultiPlan participating provider that is treated as an  
7 out-of-network claim—otherwise known as a “non-contract” or “retail” claim—is not  
8 subject to any contract, much less the MultiPlan Provider Participation Agreement.

9 113. Through its network rental business, MultiPlan has aggregated more than  
10 3.5 petabytes of claim and reimbursement data. Such data reflects not only what  
11 healthcare providers charge for in-network and non-contracted services, but also what  
12 those physicians are willing to accept as payment for those services. MultiPlan refers to  
13 this cache of data as the “crown jewels” of its company.

## 14 2. MultiPlan 2.0

15 114. Just as Ingenix was being investigated for antitrust violations and fraud in  
16 the late 2000s, MultiPlan began offering a new service to its insurance company clients:  
17 “re-pricing” their out-of-network (or “non-contracted”) claims. This is a euphemism for  
18 telling insurers how much to pay providers who perform out-of-network services for  
19 their subscribers.

20 115. In August of 2009, mere months after the rash of NYAG settlements that  
21 would shutter Ingenix, MultiPlan announced that it had reached an agreement to  
22 acquire the data analytics firm, Viant, Inc.

23 116. Viant, like MultiPlan, operated a rental PPO network; but it also offered  
24 “non-network cost management services” and a post-payment audit service. The  
25 acquisition of Viant thus “added analytics-based services” and “re-pricing solutions” to  
26 MultiPlan’s business portfolio. The Viant acquisition was completed in 2010.

27 117. In June 2011, MultiPlan acquired another company, National Care  
28 Network, LLC (“NCN”) for \$50 million. Around this time, NCN described itself as a

1 national leader in cost management, boasting powerful data-driven tools and technology  
2 solutions. At the time of MultiPlan’s acquisition, NCN had a patent application  
3 pending for a software program that would become central to the MultiPlan Cartel; that  
4 program would eventually be known as “Data iSight.”

5 118. In December 2014, adding to its so-called analytics-based services  
6 portfolio, MultiPlan acquired another company called Medical Audit and Review  
7 Solutions (MARS).

8 119. Through these acquisitions, MultiPlan became the “leader in out-of-  
9 network cost containment.” In 2022 alone, MultiPlan processed 546 million out-of-  
10 network claims. During that same year, its next closest competitor, Zelis (a company  
11 that reprices out-of-network claims based on a UCR benchmark) processed only 2  
12 million out-of-network claims.

13 120. Over time, MultiPlan’s analytics-based services have contributed an  
14 increasing share of the company’s annual revenues, now accounting for roughly 70% of  
15 total revenues. MultiPlan reported \$561 million in 2019 revenues from its analytics-  
16 based services, leaping to \$713 million by 2022. Meanwhile, MultiPlan’s revenues from  
17 network-based services dropped from \$314 million in 2019 to \$245 million in 2022.

18 121. For a time, MultiPlan purported to employ several different algorithmic  
19 repricing programs, including Viant and Data iSight. However, on information and  
20 belief, MultiPlan has consolidated those programs into one. In its 2022 10-K, MultiPlan  
21 references Viant only once (in the “corporate history” section) and describes the  
22 company’s claims re-pricing business as utilizing only one repricing algorithm: the  
23 “Data iSight program.” Whatever MultiPlan calls its “algorithms” and “solution sets,”  
24 they all pull data from the same database, operate in the same way, and serve the same  
25 function—to facilitate price-fixing in the market for out-of-network provider services.

26 **E. MultiPlan’s Claims Pricing Services.**

27 122. MultiPlan’s out-of-network claims repricing services are two-fold: First,  
28 MultiPlan makes re-pricing determinations based on its Data iSight program; these

determinations involve both an algorithmic component as well as direct input from MultiPlan personnel, who work with insurers to choose pricing strategies and algorithmic overrides—*i.e.*, rate caps—to fix and standardize rates, and manipulate the market. Second, MultiPlan negotiates the terms of payment with providers, ensuring that all payments are conditioned on the promise that the provider will not balance bill the patient. As described below, both of these services are important to the MultiPlan Cartel’s ability to fix prices for the industry, while protecting cartel members from competitive harms (like subscriber and provider abrasion).

### 1. The Data iSight Methodology

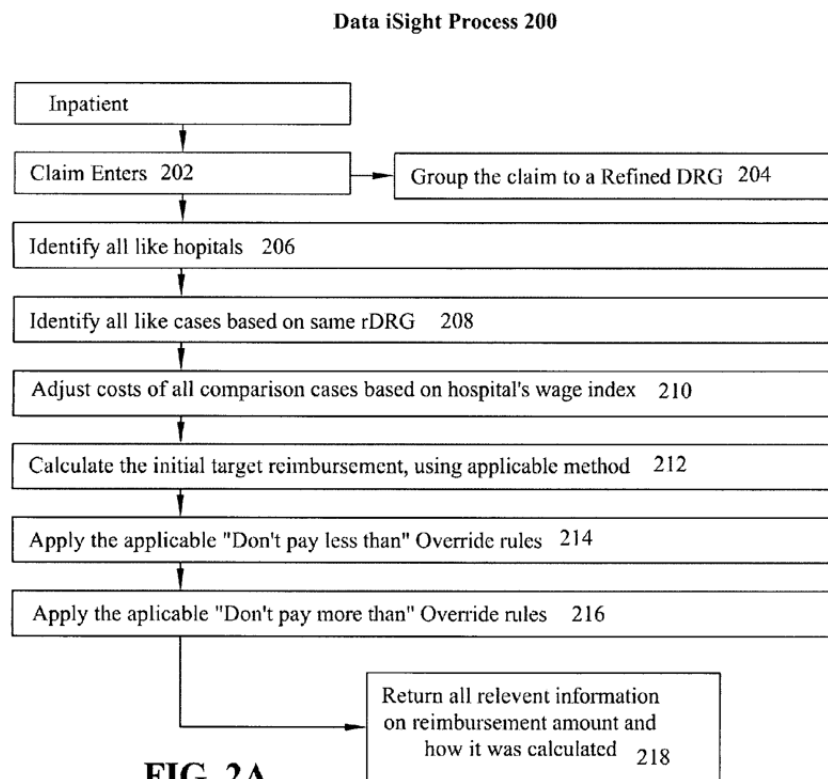
123. The precise method by which MultiPlan sets reimbursement rates is non-public and proprietary. On information and belief, MultiPlan maintains internal white papers that describe in detail the processes that it uses to reprice out-of-network claims. However, public statements by MultiPlan employees, promotional materials, and U.S. Patent No. 8,103,522 (the “522 patent,” submitted by MultiPlan subsidiary National Care Network, LLC) describe MultiPlan’s repricing methodology to some extent.

124. MultiPlan purports to calculate out-of-network reimbursements based not on a percentage of the prevailing charge rate (*i.e.*, UCR), but on “what people are actually paying within the marketplace” or “typical reimbursement rates.” It calls this methodology “Data iSight.” Insurers who contract with MultiPlan for repricing services automatically send their out-of-network claims to MultiPlan. Then, for each claim, MultiPlan determines a reimbursement amount based the “amounts generally accepted by providers as payment in full for [like] services.”

125. While MultiPlan dresses up its repricing methodology in technological jargon, it has been forced to admit in legal proceedings that once the algorithm establishes a comparator set, in most cases it simply calculates the “median” payment amount for like services.

126. According to the ’522 patent, the process of establishing a comparator set depends in part on what kind of claim is being repriced. For an inpatient hospital care

claim, Data iSight uses rDRG values (“refined Diagnosis Related Groups”) as benchmarks. rDRG is a system created by the Center for Medicare and Medicaid Studies (“CMS”); it classifies claims according to type of care, severity, and complexity. When repricing an inpatient claim, Data iSight searches the MultiPlan claims database for other bills for the same rDRG value at other “like” hospitals, then makes a cost adjustment based on the treating hospital’s wage index, as shown in Figure 2A of the ’522 patent, below:



**FIG. 2A**

127. For outpatient treatment claims, Data iSight uses the Healthcare Common Procedure Coding System (or HCPCS), another CMS-developed system. HCPCS is a collection of standardized codes that represent medical procedures, supplies, products, and services used to facilitate the processing of health insurance claims. Data iSight searches the MultiPlan claims databases for other bills for the same services, on a code-by-code basis, and then makes an adjustment based on the wage index where the treatment was rendered, as shown in Figure 2B of the ’522 patent below:

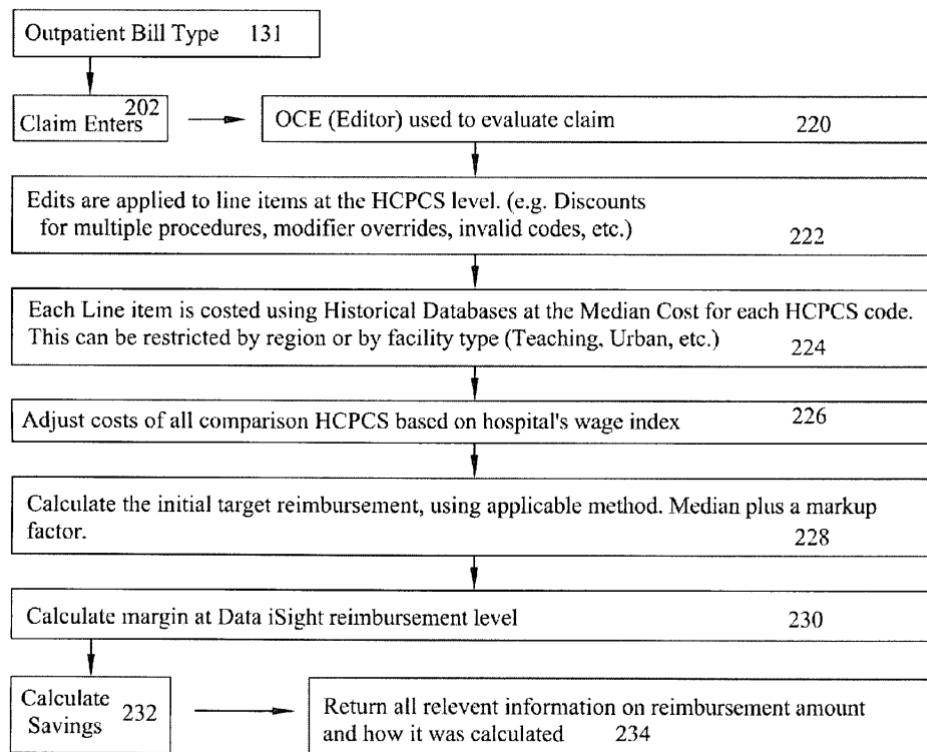


FIG. 2B

128. MultiPlan claims that Data iSight is a highly accurate, fair, and transparent way to calculate rates based on certain reasonable benchmarks. But in reality, MultiPlan ensures that Data iSight always generates artificially low reimbursement rates.

**a. MultiPlan pollutes its database.**

129. MultiPlan (like its predecessor, Ingenix) includes in its dataset payments made pursuant to network agreements. These in-network payments are then fed to Data iSight as comparators, resulting in a “garbage in, garbage out” dynamic. As discussed above, network rates, which are heavily discounted, do not represent reasonable benchmarks for the reimbursement of out-of-network claims because providers would not offer discounts to payers absent the promise of increased patient volume that comes with network participation. By intentionally corrupting its database with heavily discounted in-network payments, MultiPlan intentionally suppresses apparent “typical” or “median” reimbursement levels for out-of-network care.

**b. MultiPlan applies algorithmic overrides.**

130. MultiPlan’s supposedly sophisticated algorithm merely identifies the median payment amount for like services, based on junk data that MultiPlan feeds its database to suppress those median amounts. However, MultiPlan does not stop there in its efforts to suppress and coordinate industry-wide rates.

131. For many if not most of its insurer clients (including all of the Insurer Defendants), MultiPlan overrides the algorithm’s functioning by instructing payers to enter manual overrides, like caps and floors on payment. These overrides provide MultiPlan an additional means to control and coordinate insurer behavior, thereby reducing member and provider “abrasion” and accelerating the Cartel’s goal of suppressing industry-wide out-of-network reimbursement rates.

132. How does MultiPlan implement these overrides? Under MultiPlan’s claims repricing services agreements, each insurer client must complete a “Data iSight Client Preferences form.” However, the insurer is not free to independently select these preferences. Instead, the insurer and MultiPlan must “mutually agree[] upon” certain “business criteria” by which to set such preferences. In other words, MultiPlan maintains control over these selections.

133. The available “business criteria” are seven “methods” for setting rates, which are devised by MultiPlan. Most of these “methods” cap the amount the insurer is willing to pay for a particular service (regardless of what a reasonable payment would be or what the algorithm would otherwise spit out). For example, one available Data iSight “method” is “[r]eimbursement at which X% of hospitals are profitable.” Under this method, insurers and MultiPlan decide to reimburse at a level at which 50% of hospitals lose money for the service provided—fair and reasonable indeed. Another method is “[r]eimbursement at X% of Medicare,” meaning MultiPlan and the insurer agree to pay no more than a certain percentage of what Medicare pays for a service. The remaining five methods are: “reimbursement at which the average markup is X%”; “reimbursement at X% of cost”; “reimbursement at X% of charges”; “reimbursement at X

percentile of billed charges” (*i.e.*, UCR); and “reimbursement at average of billed charges,” as shown below in Table 1 of the ’522 patent:

Available Methods	
F1	Reimbursement at which X % of Hospitals are profitable
F2	Reimbursement at which the average mark-up is X %
F3	Reimbursement at X % of Cost
F4	Reimbursement at X % of Medicare Reimbursement
F5	Reimbursement at X % of Charges
F6	Reimbursement at X Percentile of Billed Charges
F7	Reimbursement at Average Billed Charges

134. Data iSight uses these “methods” to formulate an “initial target reimbursement amount” irrespective of the “median” reimbursement rate. This initial target amount largely determines how providers who participate in the MultiPlan network will be reimbursed for claims they submit to MultiPlan’s insurer clients.<sup>6</sup> When an insurer receives a claim from a provider that is not part of its own PPO network, the insurer sends the claim to MultiPlan. If the provider is a member of MultiPlan’s rental network, MultiPlan calculates the expected payment under that agreement’s Contract Rates. But instead of just paying the calculated amount, MultiPlan compares that amount to the “target reimbursement amount,” which is essentially an upper limit on payment. If the expected Contract Rate amount is greater than the target, MultiPlan will not pay the Contract Rate and will instead shunt the claim back to Data iSight to be “re-priced” like any other out-of-network claim.

<sup>6</sup> As described above, under MultiPlan’s nebulous Provider Participation Agreement, doctors are not guaranteed to receive the enticing Contract Rates outlined by MultiPlan. Instead, their claims may be reimbursed in whatever way the insurer and MultiPlan ultimately see fit. In practice, and as contemplated in MultiPlan’s network rental agreements with insurers, this means that the purported Contract Rates will be paid only if such rates are below the insurer’s “initial target reimbursement amount,” which, on information and belief, rarely occurs.

135. Next, MultiPlan can instruct payers to apply additional overrides to determine the final reimbursement amount. These overrides include additional “ceiling” and “floors,” as shown below in Table 1 of the ’522 patent:

Available Overrides	
O1	Don’t Pay Less Than X % of Claim’s Cost
O2	Don’t Pay Less Than X % of Claim’s Charge
O3	Don’t Pay Less Than X % of Claim’s Reimbursement
O4	Don’t Pay More Than X % of Claim’s Cost
O5	Don’t Pay More Than X % of Claim’s Charge
O6	Don’t Pay More Than X % of Claim’s Reimbursement
O7	Don’t Pay More Than Billed Charges

136. While some of MultiPlan’s available “methods” and “overrides” appear to be floors on payment (*e.g.*, “Don’t pay less than...”), in reality, these apparent “floors” are almost always paired with “ceilings” (“Don’t pay more than...”). By applying both a floor and a ceiling on payment, MultiPlan and the payer functionally decide the exact level at which to set reimbursement rates.

137. These agreed-upon payment levels are usually pegged to “barebones” Medicare rates (which do not even cover provider costs)—the long-held goal of the insurance industry. Indeed, between 2019 and 2022, Medicare reimbursements only increased by 7.5% while hospital expenses increased 17.5% over the same period. Overall, for every \$100 a hospital spends to treat a Medicare recipient, Medicare reimburses only \$84, which isn’t sustainable. Even Medicare-pegged rates that may sound reasonable can strain medical practices. For example, paying around 120 percent of the government-set Medicare rate “sounds fair, maybe even generous,” one MultiPlan document states, but this is “inherently misleading” because “the average consumer does not understand just how low Medicare rates are.” Data iSight’s often recommends prices between 160 to 260 percent of Medicare rates, amounts former MultiPlan employees described as “ridiculously low” and “crazy low.”

138. For example, during the process of reaching “mutual agreement” as to the business criteria and overrides to be used to set UnitedHealth’s out-of-network reimbursements in 2017, MultiPlan explained that with an “override” of 350% of

1 Medicare rates, UnitedHealth would be “leading the pack,” alongside one other  
 2 competitor, in terms of how low it could drive out-of-network reimbursements. But an  
 3 override of 500% of Medicare would put UnitedHealth in line with what the rest of what  
 4 its main competitors were doing. This information about competitor pricing practices  
 5 was competitively sensitive data that would not have been shared among insurers but  
 6 for operation of the MultiPlan Cartel. And, consistent with the Cartel’s goal of reducing  
 7 industry-wide OON reimbursement rates over time, UnitedHealth reduced its payment  
 8 ceiling from 500% of Medicare rates in 2016, to 350% in 2018, and 250% thereafter.

9       139. The rate determinations generated by these overrides often do not take  
 10 into account geographical differences in the cost of key inputs like labor. Numerous  
 11 providers have observed that MultiPlan reprices claims submitted to UnitedHealth  
 12 based on a Medicare benchmark, often with no geographical adjustment. For example,  
 13 Freemont Emergency Services (an emergency room physician group that successfully  
 14 sued UnitedHealth for suppressing out-of-network reimbursements) documented that  
 15 between January and May of 2019, it submitted identical claims to UnitedHealth for  
 16 the same service performed in nine different states. While these bills varied in amount,  
 17 each was equal to exactly 80% of UCR in the geographical region where the service was  
 18 performed, as calculated by FAIR Health at the time. Had these bills been submitted to  
 19 UnitedHealth during the time in which FAIR was used to set reimbursement rates,  
 20 each bill would have been paid at exactly the amount charged. But, after having those  
 21 claims repriced by MultiPlan, UnitedHealth paid these healthcare providers far less.  
 22 For each of the nine treatments in nine different states stretching from one coast to  
 23 another, MultiPlan calculated, and UnitedHealth paid, a reimbursement of exactly  
 24 \$413.39. This resulted in an underpayment to healthcare providers of between \$381.61  
 25 and \$939.61 (or 45% and 70% off of the relevant UCR benchmark).

## 26                   **2. MultiPlan’s Negotiation Services**

27       140. After determining a payment amount via the Data iSight methodology,  
 28 MultiPlan negotiates payment with providers. This negotiation function is critical to

1 ensuring that all insurers adhere to MultiPlan's payment determinations, and to  
2 MultiPlan's ability to orchestrate the conspiracy.

3 141. MultiPlan makes offers of payment to providers on a take-it-or-leave-it  
4 basis. Typically, MultiPlan gives medical billers less than ten days to respond to its  
5 offers and threatens to drop its reimbursements should providers choose not to accept.  
6 In one fax to a healthcare provider, MultiPlan gave the provider eight days to respond  
7 to a low-ball offer, warning: "if you do not wish to sign the attached proposal . . . this  
8 claim is subject to a payment as low as 110% of Medicare rates based on the guidelines  
9 and limits on the plan for this patient."

10 142. If the medical biller tries to negotiate for a higher rate with MultiPlan,  
11 MultiPlan says it is not the insurer and does not have authorization to increase the  
12 payment offer. If the biller asks the insurer how MultiPlan reprices its claims, the  
13 insurance company explains that it is not responsible for MultiPlan's pricing.

14 143. But is not enough to simply force providers to accept the extremely low  
15 payment amounts calculated by Data iSight. To avoid patient backlash and subscriber  
16 loss for its insurer clients, MultiPlan must also ensure that providers will not hold  
17 patients liable for the remainder of the bill. So, MultiPlan conditions all offers of  
18 payment on the provider's promise not to "bill the Patient, or financial responsible  
19 party, for the difference between the Billed Charges and the Proposed Amount [*i.e.*, the  
20 payment offer]."

21 144. MultiPlan knows it can get away with acting like mafia enforcer for  
22 insurers because virtually every commercial healthcare payer has agreed to use its  
23 repricing methodology, leaving healthcare providers with no practical option but to  
24 accept the "repriced" reimbursement amount that MultiPlan imposes. Across all claim  
25 types, in over 95% of cases, providers accept the initial reimbursement offer made by  
26 MultiPlan, and do so, as required, on the condition that they will refrain from balance  
27 billing the patient. The number is even higher, roughly 99.4%, for inpatient claims.  
28

1           145. MultiPlan “eliminate[s] balance billing” among the miniscule percent of  
 2 providers who appeal the initial reimbursement offer by providing “post-payment  
 3 negotiation” services to payers. As part of this service, MultiPlan again tells providers  
 4 that that if they do not accept the offer, they may receive no reimbursement at all. The  
 5 vast majority of these appeals result in providers accepting of the MultiPlan offer, again  
 6 on the condition they will not balance bill the patient.

### 7                           **3. MultiPlan’s Contingent Fee Structure.**

8           146. For each claim MultiPlan reprices, it collects a fee from the insurer based  
 9 on the difference between the provider’s original claim and the amount the provider  
 10 eventually accepts. This fee is typically equal to 5-7% of the “savings” obtained by  
 11 MultiPlan but has been as high as 9.75% in some cases.

12           147. MultiPlan is thus highly motivated to calculate the lowest reimbursement  
 13 rates possible—whether or not “reasonable” or “fair” to the provider. Indeed, these  
 14 contingent fees represent the lion’s share of the MultiPlan’s annual revenues. In 2021  
 15 alone, MultiPlan raked in roughly \$709 million in fees for repricing OON claims.

## 16                           **VII. DEFENDANTS’ ANTICOMPETITIVE SCHEME**

17           148. A cartel is a group of rivals that conspire to fix prices, allocate markets, or  
 18 otherwise illegally limit competition. Cartels can be organized by competing sellers of  
 19 goods or services (who seek to raise prices to increase their revenues) or by buyers (who  
 20 seek to suppress prices to reduce their costs). Either way, the goal of cartel members is  
 21 the same: to act (collectively) like a monopolist—or in the case of a buyers’ cartel, such  
 22 as the cartel alleged herein, like a monopsonist.

23           149. The MultiPlan Cartel is a buyers’ cartel dating back to around 2015 (and  
 24 perhaps earlier) designed to reduce out-of-network claims reimbursement rates. To  
 25 achieve this outcome, cartel members agree (among themselves and with MultiPlan,  
 26 which orchestrates their scheme) to: (1) outsource their competitive decisions with  
 27 respect to out-of-network reimbursement rates to a common decisionmaker, MultiPlan,  
 28 and abide by its price determinations, and (2) exchange among themselves and

1 MultiPlan competitively sensitive information regarding their reimbursement rates and  
2 pricing strategies. This joint delegation and anticompetitive information exchange  
3 allows MultiPlan to coordinate insurer behavior and minimize industry-wide  
4 reimbursement rates.

5 **A. MultiPlan invites insurers to participate in collective action.**

6 150. As a sophisticated market participant, MultiPlan is aware that its out-of-  
7 network claims repricing services are attractive to insurers only if insurers perceive an  
8 opportunity to collectively adopt the same pricing methodology and negotiation  
9 strategy.

10 151. It is well understood that a single insurer, acting alone, will face massive  
11 subscriber and provider backlash (or “abrasion”) if it reimburses out-of-network claims  
12 at below-market, Medicare-style rates. Historically, when insurers refused to pay a  
13 reasonable rate of reimbursement on out-of-network claims (and used Medicare rates as  
14 the reference point), providers would balance bill patients, leading to subscriber  
15 complaints, appeals, and departures. Insurers thus understand that to successfully  
16 lowball providers (without risking serious economic harm), they must not only force  
17 providers to accept low reimbursement rates, but to do so on terms that preclude  
18 balance billing, something no individual insurer would have sufficient leverage to do on  
19 its own. In other words, it would be against the unilateral economic self-interest of any  
20 one insurer to join the MultiPlan Cartel, absent awareness that competitors had agreed  
21 to do the same.

22 152. MultiPlan offers a solution to this dilemma, inviting insurers to act  
23 collectively with respect to their reimbursement decisions and provider interactions. To  
24 that end, it markets its platform as a way for insurers to “outsource the repricing” and  
25 negotiation of “out-of-network claims” to a single decision-maker, MultiPlan. According  
26 to MultiPlan, by delegating these functions to MultiPlan, “[c]ommercial plans of any  
27 size” can obtain significant “discounts on out-of-network charges” while ensuring “low  
28 provider abrasion” and “minimizing the balance billing of their members.” Such

1 marketing contemplates and invites concerted action among insurers as a means to  
2 reduce out-of-network costs. Insurers sacrifice their independent decision-making to a  
3 common decisionmaker (MultiPlan) only because they know competitors are doing the  
4 same.

5 153. As part of this scheme, MultiPlan also invites and requires insurers to  
6 participate in anticompetitive information sharing. MultiPlan requires each insurer  
7 client to submit real-time, non-public pricing information to its database, including:

8 (1) claims (both in- and out-of-network) received from  
9 providers,

10 (2) reimbursements paid to those providers, and

11 (3) proprietary pricing preferences and strategies, which  
12 MultiPlan solicits (among other ways) through its mandatory  
“Data iSight Client Preferences form.”

13 154. This pricing information (including the caps and overrides applied by  
14 insurers, via mutual agreement with MultiPlan) constitute competitively sensitive  
15 information that would not be shared in a competitive market. An insurer equipped  
16 with knowledge of a competitor’s pricing data and strategies could gain a competitive  
17 advantage and seize market share by reimbursing out-of-network providers at higher  
18 rates than a lowballing competitor. It would be against the economic self-interest of  
19 any independent insurer to share that competitively sensitive data with MultiPlan, for  
20 use with its competitors (whether directly or indirectly), unless it knew that its  
21 competitors were doing the same. Absent such an assurance, an insurer would be  
22 undermining its competitive standing vis-à-vis other insurers.

23 155. MultiPlan is transparent that the value of its services stems from its  
24 ability to harvest competitively sensitive payment data from hundreds of insurance  
25 companies, and to use that data to set rates for the entire industry. MultiPlan touts its  
26 “incomparable database”—populated with some 135 million claims a year, or “360,000  
27 claims a day,” from “700-plus payer customers”—as the single most “impressive” fact  
28

1 about the company, and the real reason insurers stand to benefit from the decision to  
2 “outsource the pricing of [their] out-of-network claims” to MultiPlan.

3 156. As one former MultiPlan executive, Paul Galant, signaled to the market on  
4 a 2020 earnings call, MultiPlan’s ability to collect “claims from 700 payers” made the  
5 company’s repricing tools “very, very different” from those operated by a “single payer”  
6 (such as Naviguard, UnitedHealth’s in-house repricing tool). According to Galant,  
7 MultiPlan’s access to industry-wide data, rather than its technology, was the reason  
8 “why [insurers] all come to MultiPlan” for claims repricing. And he boasted that  
9 MultiPlan’s “data advantage” had created a “competitive moat around [the] company  
10 that drives recurring revenues.”

11 157. Galant doubled down on these comments during a Virtual Analyst Day  
12 later in 2020. According to Galant, MultiPlan’s value proposition had nothing to do  
13 with technology, bluntly stating that anyone can “create their own algorithms.” The  
14 MultiPlan “difference,” he explained, was that “we see data across 700 payors,” enabling  
15 the company to “generate bigger savings” for clients and to obtain better concessions  
16 from providers in negotiations. According to this executive, because MultiPlan can  
17 “talk to the entire industry”—rather than just one “specific payer”—it was better  
18 equipped to “push for savings” than a payer, acting individually, “who decides to do  
19 everything on their own.” In other words, MultiPlan could deliver results for insurers  
20 because it enabled their collective action.

21 158. To attract new cartel members (and ensure the ongoing participation of  
22 existing members), MultiPlan regularly announces how many insurers are part of its  
23 price-fixing scheme. In 2020, Mark Tabak, then-CEO of MultiPlan, stated publicly that  
24 the company was “the leader in out-of-network cost containment” and had entered into  
25 “multi-year contracts with the leading payers” to provide OON claims repricing service.  
26 Likewise, in 2023, MultiPlan executives bragged that “all of the top 15 insurers” in the  
27 country had agreed to use MultiPlan’s out-of-network claims repricing services.  
28

1           159. MultiPlan makes the same kinds of representations in private to insurers.  
 2 For example, MultiPlan’s former Chief Revenue Officer, Dale White, induced  
 3 UnitedHealthcare to join the Cartel in 2016, stating in an email that seven of the  
 4 insurer’s top ten competitors were already using MultiPlan’s repricing services.  
 5 According to the White, “[i]mplementing these initiatives [would] go a long way to bring  
 6 UnitedHealth back into alignment with its primary competitor group [Blues, Cigna,  
 7 Aetna] on managing out-of-network costs.” One of the recipients of White’s email,  
 8 UnitedHealthcare executive Rebecca Paradise, would later testify that a key factor in  
 9 UnitedHealth’s decision to use MultiPlan was that it was “widely used by our  
 10 competitors.” Such statements confirm that concerted action is the point of the  
 11 MultiPlan Cartel, and that the Insurer Defendants join it precisely because their  
 12 competitors have also agreed to do so.

13           160. White’s email to UnitedHealth was nothing more than an invitation to  
 14 collude. And it assured UnitedHealth’s executives that by joining the collusive scheme,  
 15 UnitedHealth’s OON reimbursements would be “aligned” with those of its competitors,  
 16 thus enabling the insurer to lowball providers without suffering competitive harms or  
 17 “abrasion.” This same dynamic has played out with countless other insurers.

18           **B. Insurers accept MultiPlan’s invitation to collude.**

19           161. As MultiPlan regularly boasts, over 700 insurers, including all of the  
 20 nation’s top 15 healthcare payers, have accepted MultiPlan’s invitation to participate in  
 21 concerted action with respect to the pricing of out-of-network claims. These insurers  
 22 show their acceptance of MultiPlan’s invitation to collude in at least three ways.

23           **1. Joint Delegation**

24           162. Insurers enter into contracts with MultiPlan through which they delegate  
 25 to MultiPlan the authority to determine out-of-network reimbursement rates and  
 26 negotiate those rates with providers to ensure they accept them. The very act of  
 27 contracting with a common third party to determine rates and negotiate with providers  
 28

1 signals insurers' conscious commitment to adhere to MultiPlan's price determinations,  
2 facilitating their collective action.

3 163. Under MultiPlan's OON claims repricing services contracts, insurers agree  
4 to set payment preferences through "mutual[] agree[ment]" with MultiPlan, and abide  
5 by MultiPlan's "negotiated rates" so long as they are "consistent with the business  
6 criteria mutually agreed upon between [the insurer] and MultiPlan." Through these  
7 provisions, insurers delegate to MultiPlan control over key business decisions that  
8 directly impact reimbursement rates. The fact that all of MultiPlan's insurer clients  
9 cede control to MultiPlan in this way enables MultiPlan to orchestrate uniform  
10 behavior by each of its insurer clients to achieve their common, illicit goal of  
11 suppressing reimbursement rates across the board—a goal from which MultiPlan  
12 profits handsomely.

13 164. By outsourcing their independent decision-making and negotiation  
14 authority to a mutually agreed-upon third party, insurers know that they will not (and  
15 cannot) be disciplined by providers for setting ever-lower reimbursement rates.  
16 Providers are forced to accept unprecedentedly low reimbursements rates, without  
17 recourse to balance billing, because virtually all insurers now use MultiPlan's out-of-  
18 network claims repricing services. In other words, healthcare providers have nowhere  
19 to turn for better terms, and must deal with MultiPlan or receive no reimbursements at  
20 all (and rely solely on payments from patients).

## 21 2. Anticompetitive Information Exchange

22 165. Insurers provide MultiPlan with copious amounts of competitively  
23 sensitive data, including their payment data and payment preferences (including the  
24 overrides and caps they enter into Data iSight).

25 166. Insurers share this data with MultiPlan because they know that MultiPlan  
26 will use it to assist them and their co-conspirators (including through the setting of  
27 OON reimbursement rates and the effectuation of pricing strategies). They also  
28

1 participate in information sharing so that they can benefit from the proprietary data  
2 their competitors are likewise providing to MultiPlan.

3 167. MultiPlan's relationship with UnitedHealthcare illustrates how the  
4 company leverages insurers' proprietary payment data and pricing strategies to effect  
5 its scheme to suppress industry-wide OON prices:

6 168. In 2016, MultiPlan induced UnitedHealthcare to join the Cartel by  
7 representing that its major competitors had already entered into repricing services  
8 agreements with MultiPlan. In 2017, MultiPlan instructed UnitedHealth to pursue a  
9 specific, aggressive override strategy, based on what MultiPlan's other insurer clients  
10 were doing, that would drive down industry-wide reimbursement rates. In particular,  
11 MultiPlan's Dale White instructed that UnitedHealthcare set out-of-network payments  
12 at 350% of Medicare rates, assuring UnitedHealthcare executives that, by agreeing to  
13 use this formula, UnitedHealthcare would "be in line with [one] competitor" and  
14 "leading the pack along with another competitor." MultiPlan was aware of the pricing  
15 strategies of UnitedHealthcare's competitors because, as MultiPlan clients, they had set  
16 those benchmarks via "mutual agreement" with MultiPlan. MultiPlan then used that  
17 information to make a similar instruction to UnitedHealth. Thus, MultiPlan's role as a  
18 clearinghouse for each Insurer Defendant's and each co-conspirator's competitively  
19 sensitive and otherwise non-public pricing data is essential to its ability to orchestrate  
20 the MultiPlan Cartel, and to bring each Insurer Defendant's and each co-conspirator's  
21 practices in alignment with the cartel's overall pricing moves.

22 169. Against this backdrop, UnitedHealthcare's pricing became increasingly  
23 aggressive over time, backed by MultiPlan's assurances that its OON reimbursements  
24 were still consistent with industry norms. Eventually, UnitedHealthcare agreed with  
25 MultiPlan to implement a cap of 250% of Medicare rates in Data iSight. As  
26 UnitedHealthcare executives later explained in a Customer Impact Advisory Brief, it  
27 was "utilizing Data iSight, owned by MultiPlan, to administer [an outlier cost  
28 management program]" and "90 other payors nationwide use [Data iSight] in a similar

1 manner.” UnitedHealthcare’s agreement to MultiPlan’s proposed cap thus turned on its  
 2 understanding that its competitors had already entered similar agreements with  
 3 MultiPlan. Absent that assurance, it, like its competitors, would not enter such an  
 4 agreement because it would be against their independent economic interests.

5 170. MultiPlan has leveraged its access to insurers’ proprietary data and  
 6 preferences to orchestrate similar agreements with each of the largest health insurance  
 7 companies in the United States, which would otherwise be competing amongst  
 8 themselves for the services of OON providers by paying market rates.

### 9 3. Adherence to MultiPlan’s Pricing Determinations

10 171. Insurers abide by MultiPlan’s price determinations. MultiPlan enforces  
 11 this outcome through its contracts with insurers. Pursuant to MultiPlan’s standard  
 12 OON claims repricing services contract, the insurer cannot set their reimbursement  
 13 rates as they see fit. Pricing preferences can only be entered by “mutual agreement”  
 14 with MultiPlan. Moreover, the insurers’ ability to deviate from the Data iSight rate is  
 15 constrained, as each insurer agrees “not to reduce the . . . provider’s rate for claims for  
 16 which [MultiPlan] has negotiated a rate . . . provided that the negotiated rate is  
 17 consistent with the business criteria mutually agreed upon between [the insurer] and  
 18 MultiPlan.” The business criteria set by insurers are also informed by MultiPlan’s  
 19 access to and divulging of the competitively sensitive information of other insurers.  
 20 Because it would be economically irrational for an insurer to pay *more* than a  
 21 healthcare provider was willing to take, the bar on reducing a provider’s rate below  
 22 what MultiPlan has determined constitutes a tacit agreement by the insurer to pay  
 23 exactly what MultiPlan instructs it to pay.

24 172. This tacit agreement is borne out in practice. MultiPlan processes some  
 25 370,000 claims per day for its clients. Given this volume, insurers cannot (and do not)  
 26 independently assess whether MultiPlan’s algorithmically adjusted rates are  
 27 reasonable. Instead, virtually all MultiPlan-generated rates are sent to providers  
 28

(usually by MultiPlan itself) with no modification whatsoever on the part of the insurer (or any other form of “human touch”).

173. In some 95-99% of cases, providers accept the MultiPlan generated rates initially offered, on the condition that they will “not . . . bill the Patient, or financially responsible party [*i.e.*, the patient], for the difference between the Billed Charges and the Proposed Amount [offered].”

174. As a result, the MultiPlan rate determination is the final payment amount in virtually all cases.

**C. Direct and indirect evidence of the MultiPlan Cartel exists.**

**1. Direct evidence of a horizontal agreement.**

175. MultiPlan is a horizontal competitor of the Insurer Defendants, a fact which flows from its position as a nationwide PPO network operator.

176. As described above, to attract providers to its rental network, MultiPlan must offer them competitive reimbursements rates (and other inducements, such as patient steerage); if MultiPlan offers rates (or other terms) that are inferior to what competitor networks offer, it will lose the battle for providers.

177. In this contest for providers, MultiPlan competes against insurers that offer PPO plans, including the Insurer Defendants. Thus, as MultiPlan has admitted in public filings, MultiPlan “compete[s] with regional PPOs targeting primary network business,” and “with PPO networks *owned by [its] large Payor customers.*”

178. MultiPlan has entered agreements with some 700 insurers, including the Insurer Defendants, which expressly contemplate that MultiPlan and the insurer will collude to set the reimbursement levels for out-of-network claims. These contracts include an agreement to share proprietary data, to use MultiPlan’s repricing technologies to lower payments made on claims for reimbursement by out-of-network healthcare providers, and to allow MultiPlan to negotiate rates with providers to eliminate balance billing. Several of these contracts are publicly available.

179. One agreement between MultiPlan and Aetna, for example, provides that the parties must mutually agree upon pricing preferences, and that Aetna will honor rates negotiated by MultiPlan so long as they are “consistent with the business criteria mutually agreed upon between [Aetna] and [MultiPlan].” The parties also agree “[w]here the negotiated amount is less than the original billed charge,” MultiPlan must “obtain the provider’s signed agreement to the revised amount or secure proper documentation stating no ‘balance bill’ to the patient except for deductible, co-insurance and non-covered services based on the providers’ adjusted price[.]”

**2. Indirect evidence of a horizontal agreement.**

**a. Insurers engage in actions which, absent concerted action, would be against their individual economic self-interest.**

180. As part of the MultiPlan Cartel, each Insurer Defendant engages in numerous actions, which (in the absence of concerted action) would be against their individual economic self-interest, but which, in the context of the scheme, maximize profits for the collective. These “actions against self-interest” are strong circumstantial evidence of a horizontal agreement among insurers to reduce competition for OON providers and suppress reimbursement rates.

181. First, it would be against the economic self-interest of any individual Insurer Defendant to lowball OON providers (the goal and consequence of using MultiPlan, including through agreements to implement aggressive rate caps) because doing so is well known to cause member and provider “abrasion” and, ultimately, economic harm. In the absence of collusion, insurers would pay competitive rates to avoid such economic harm, including subscriber dissatisfaction and loss.

182. Second, it would be against the economic self-interest of any individual Insurer Defendant to pay for MultiPlan’s expensive claims re-pricing services when there are far cheaper, comparable services on the market, including but not limited to those offered by FAIR Health, Inc. Unlike FAIR—which charges insurers a modest, flat annual fee—MultiPlan assesses its clients a fee *for each repriced claim*, which is based

1 on a percentage of the difference between the billed amount and the sum ultimately  
2 paid. For any individual insurer, these contingent fees far exceed the flat annual fee  
3 they would have to pay to use FAIR. As such, absent collusion, insurers would not pay  
4 MultiPlan's fees and would use FAIR or another cheaper vendor. They only do so  
5 because the insurers and MultiPlan, collectively, do much better by essentially dividing  
6 their monopsony profits, than they would in a fair, functioning, and competitive market  
7 not mired by collusion.

8 183. Third, it would be against the economic self-interest of any individual  
9 Insurer Defendant (all of which are sophisticated, well-resourced companies) to use  
10 MultiPlan when they could simply develop their own internal algorithms to re-price  
11 OON claims and avoid paying fees to a third-party vendor altogether. As MultiPlan has  
12 itself admitted, anyone can "create their own algorithms." And, in fact, Defendant  
13 UnitedHealth did develop such an algorithm, known as Naviguard. However,  
14 UnitedHealth scrapped Naviguard in 2020 after MultiPlan made UnitedHealth a  
15 sweetheart deal—in the form of a massive contingent fee discount—to remain within  
16 the Cartel. Absent collusion, it would have been economically irrational for  
17 UnitedHealth to scrap Naviguard after investing the resources necessary to develop it.

18 184. Fourth, it would be against the economic self-interest of each Insurer  
19 Defendant to share its competitively sensitive and proprietary pricing data and  
20 strategies with other insurers through a common third party, unless they knew all  
21 other insurers had agreed to do the same. In the absence of concerted action, insurers  
22 would not share such information with rivals (through an intermediary or otherwise)  
23 because of the risk of competitive harm. After all, competitors could use the  
24 information to make superior bids to out-of-network providers and strengthen their  
25 PPO networks and plan offerings relative to the competition.

**b. The market for OON providers is susceptible to the formation, maintenance, and efficacy of a cartel.**

185. As the Ingenix debacle shows, the insurance industry is characterized by numerous features, sometimes called “plus factors,” that render the industry susceptible to collusion and bolster the plausibility of the cartel alleged herein.

186. First, there are high barriers to entry that make it difficult for new companies to enter the commercial health insurance market with competing plans. These barriers include state and federal regulatory requirements, costs associated with developing physician and patient networks, and developing enough business volume to spread risk.

187. Second, out-of-network providers face high exit barriers when seeking reimbursement for services they provide. As noted previously, in the United States, some 90% of all healthcare costs are reimbursed, not by patients, but by third-party payers. Given this reality—along with laws and regulations limiting the ability of providers to directly bill patients—out-of-network providers generally have no substitutes for where to seek reimbursement but from a patient’s insurer. The only way for out-of-network providers to “exit” this third-party payer system is to refuse to treat patients unless they pay cash, something very few patients can afford.

188. Third, the market among health insurers is highly concentrated. In 2022, the American Medical Association (“AMA”) found that 86 percent of PPO markets are highly concentrated as calculated under the Herfindahl-Hirschman Index (HHI), a metric used by federal regulators to measure market health with respect to concentration. The AMA, moreover, found that in 58 percent of metropolitan areas, a single insurer enjoyed a 50 percent or greater market share, with a significant number of metropolitan areas witnessing a single insurer controlling market shares of 70 percent or greater.

189. Fourth, the claims submitted by out-of-network providers for reimbursement from insurers are relatively fungible. All claims are submitted using uniform billing codes, no matter the insurer or the provider. This allows MultiPlan to

1 reprice claims consistently for like claims submitted by providers to different insurers  
2 and across different health plans, across the entire country, making it feasible for  
3 MultiPlan and the Insurer Defendants to execute their anticompetitive scheme.

4       190. Fifth, members of the MultiPlan Cartel have had ample opportunities to  
5 meet and collude, including at events organized and hosted by MultiPlan itself. For  
6 instance, MultiPlan maintains a Client Advisory Board (“CAB”) that hosts lavish,  
7 multi-day retreats that bring together executives from competing health insurers  
8 (including co-conspirators United, Aetna, Cigna, Humana) to discuss topics such as  
9 MultiPlan’s ability to deliver cost savings through its programs. These retreats  
10 occurred in 2015, as well as in 2019 and 2021, and possibly at other times. In 2019,  
11 MultiPlan hosted a CAB retreat at a luxury spa in Laguna Beach, California attended  
12 by executives from MultiPlan, UnitedHealth, Aetna, Cigna, Humana, several Blue  
13 Cross Blue Shield associations, Kaiser, and other insurance companies. It held a  
14 similar event in the same city in 2021. At these meetings, MultiPlan has seated insurer  
15 invitees next to each other, which gives them an opportunity to discuss and join the  
16 Cartel. According to sworn testimony by a UnitedHealth executive, at these events,  
17 insurance executives “[t]ypically . . . talk about things they’ve implemented” using  
18 MultiPlan’s Data iSight scheme and “other things they’re looking at” to reduce out-of-  
19 network costs, and share with each other “new information” about their efforts in this  
20 regard. MultiPlan also makes its own presentations concerning cartel members’ cost  
21 reduction efforts, facilitating the exchange of sensitive, proprietary payment  
22 information between rivals.

23       191. The Insurer Defendants and MultiPlan have had opportunities to collude  
24 through other channels as well. Aetna, Centene, Cigna, CVS Health, Elevance, HCSC,  
25 Humana, and other insurers are members of AHIP (formerly, “America’s Health  
26 Insurance Plans”), a trade organization of insurers that regularly holds conferences and  
27 meetings (both public and private). MultiPlan sponsors and sends representatives to  
28 AHIP events. Numerous executives employed by the Insurer Defendants and their co-

1 conspirators sit on AHIP's Board of Directors, including: Gail K. Bourdreaux, President  
2 and CEO of Elevance; Bruce D. Broussard, President and CEO of Humana; David  
3 Cordani, Chairman and CEO of Cigna; Sarah London, CEO of Centene; Karen S. Lynch,  
4 President and CEO of CVS Health (the parent company of Aetna); and Maurice Smith,  
5 President, CEO, and Vice Chair of HCSC.

6 192. AHIP hosts conferences, committee meetings, and board meetings multiple  
7 times a year where its members participate in private, closed-door meetings. In 2023,  
8 MultiPlan sponsored AHIP's Annual Conference. Upon information and belief,  
9 MultiPlan representatives attended AHIP's 2023 Annual Conference from June 13-15  
10 in Portland, Oregon.

11 193. MultiPlan also engages in "road shows," visiting various insurance  
12 companies, including the Insurer Defendants, to provide updates regarding its claims  
13 repricing services. At these road shows, MultiPlan executives (including Dale White  
14 and Susan Mohler) have shared with insurers detailed descriptions of Data iSight's  
15 repricing methodology, the "savings" achieved by various MultiPlan customers, and  
16 recommendations to further reduce out-of-network reimbursements. During roadshow  
17 in the fall of 2021, MultiPlan bragged that it was reducing payments for out-of-network  
18 services by 61% to 81%. Upon information and belief, MultiPlan meets with each of its  
19 clients each year at such road shows, which allows the Cartel to be regularly updated  
20 and renewed.

21 194. MultiPlan also prepares white papers for its claims repricing clients, which  
22 include references to the claims repricing strategies adopted by other insurers and  
23 instruct them on how to implement the scheme.

#### 24 **VIII. RELEVANT MARKET AND MONOPSONY POWER**

25 195. If a relevant antitrust market needs to be defined, the relevant market is  
26 the market for the reimbursement of out-of-network provider services by third-party  
27 payers. The relevant geographic market is the United States.  
28

1           196. In this market, healthcare providers like Plaintiff are sellers of out-of-  
2 network medical care, while third-party payers like the Insurer Defendants are buyers  
3 of those services. Healthcare providers in this market have no reasonable substitutes  
4 for the reimbursements provided by commercial insurers for out-of-network medical  
5 services, as balance billing patients is futile or illegal in many if not most instances.

6           **IX. FRAUDULENT CONCEALMENT, CONTINUING VIOLATION, AND**  
7           **TOLLING THE STATUTE OF LIMITATIONS**

8           197. Defendants have affirmatively and fraudulently concealed the conspiracy  
9 by various means and methods from its inception.

10          198. Defendants did so in at least two ways. First, they misled Plaintiff and  
11 other providers about how reimbursement rates were set. Second, they actively worked  
12 to conceal the conspiracy and ensure its secrecy.

13          199. MultiPlan's explanation of its pricing methodology to providers was false  
14 and misleading. Moreover, MultiPlan and the other Defendants intentionally hid from  
15 the proposed Class, including Plaintiff, that reimbursement prices were actually  
16 determined by use of a shared pricing system that used Defendants' real-time, non-  
17 public claims data and combined it with their competitors' real-time, non-public claims  
18 data to set out-of-network reimbursement rates.

19          200. MultiPlan also made false and misleading statements to conceal that it  
20 colluded with and orchestrated insurers (*i.e.*, its competitors) to work in concert to  
21 artificially suppress payments to healthcare providers.

22          201. MultiPlan and the other Defendants also spent years claiming that  
23 reimbursements were derived by algorithm, when in fact they were fixed by the cartel's  
24 members.

25          202. MultiPlan and Defendants also publicly misrepresented that they did not  
26 engage in anticompetitive conduct. For example, MultiPlan's published Code of  
27 Business Conduct and Ethics states that it is "committed to conducting our business  
28

1 with integrity at all times,” and that “only legal and ethical means should be used to  
2 gather information about existing and potential competitors.”

3 203. Similarly, Aetna’s Code of Conduct provides that employees must “obey all  
4 laws and regulations that apply to Aetna’s business,” “be honest and act with integrity  
5 in all of your Aetna business dealings,” “must not be part of any conduct . . . that is  
6 intended to mislead, manipulate, or take unfair advantage of anyone, or misrepresent  
7 Aetna products, services, contract terms or policies to a . . . provider,” and “[d]o not  
8 agree with representatives of a competing company, or with others, to be part of these  
9 or any other practices that may illegally restrain competition: fixing prices . . . .”

10 204. Cigna’s Code of Ethics and Principles of Conduct contain similar  
11 misleading information. Cigna says it will “comply with applicable laws” and “will  
12 behave ethically.” It claims to only “look[] for competitive advantages through legal and  
13 ethical business practices,” that it “neither accept[s] nor tolerate[s] taking advantage of  
14 anyone through, for example, manipulating or misrepresenting information,” that it  
15 “competes fairly around the world,” that it “seek[s] to maintain and grow our business  
16 through superior products and services – and not through any improper or  
17 anticompetitive business practices” and so “compl[ies] with competition and antitrust  
18 laws throughout the world.”

19 205. UnitedHealth’s Code of Conduct also instructs employees to “[a]void  
20 discussions with competitors that may appear to restrain competition unreasonably,”  
21 including “[c]ommunications or agreements with competitors regarding . . . provider  
22 reimbursement rates . . . .” The Code specifically cautions against sharing information  
23 about provider reimbursement rates by competitors. Specifically, it addresses a  
24 hypothetical of an Optum Health employee (subsidiary of UnitedHealth): “Q. I work in  
25 Optum Health and received a request from a colleague on my old team at  
26 UnitedHealthcare for some information related to reimbursement rates of other payers.  
27 May I provide the data since we are part of the same company? A. Not without  
28 consulting your business Legal Representative or Compliance Officer. Optum Health’s

1 provider businesses contract with competitors of UnitedHealthcare and may receive  
2 competitively-sensitive information, which must be protected, and sharing the data  
3 requested without review and approval by legal counsel could be a form of unfair  
4 competition.”

5       206. Similarly, Blue Cross Blue Shield of Michigan’s Code of Business Conduct  
6 provides that the company “strives to conduct its business in a manner that helps  
7 maintain a free and competitive market,” and that “[a]ctivities that would restrain a  
8 competitive market, even artificially, are contrary to that philosophy and to antitrust  
9 laws, including: Entering into any agreement or joint conduct with competitors that  
10 would harm competition; [ . . . ]; Collaborating with a competitor to decide what to pay  
11 for services.” It specifically provides that the company should “[n]ever exchange price  
12 information or communicate with a competitor about prices, anything that may affect  
13 prices, or customers,” yet that is exactly what the company does through MultiPlan.  
14 Upon information and belief, other Blue Cross affiliates have similar provisions in their  
15 codes of conduct and ethics.

16       207. Defendants also took steps to conceal the true nature of their  
17 anticompetitive arrangement from Plaintiff and the proposed Class.

18       208. Defendants engaged in a secret and inherently self-concealing conspiracy  
19 that did not reveal facts sufficient to put Plaintiff or the proposed Class on inquiry  
20 notice.

21       209. Defendants other than MultiPlan privately submitted their own non-public  
22 claims data to MultiPlan, and MultiPlan in turn used its proprietary repricing tools, the  
23 details of which remain confidential, to propose reimbursement rates. The inner  
24 workings and true nature of this process are secrets that are not shared with providers  
25 like Plaintiff and the proposed Class.

26       210. Defendants regularly attended invitation-only industry events, including  
27 events held and sponsored by MultiPlan, where they discussed behind closed doors how  
28

1 MultiPlan's repricing tools allowed them to reduce costs by suppressing out-of-network  
2 reimbursement rates.

3 211. Defendants had private communications and meetings to discuss out-of-  
4 network claim repricing, MultiPlan's repricing tools, and use of those tools, including by  
5 each Defendant's competitors.

6 212. Plaintiff and the proposed Class therefore had neither actual nor  
7 constructive knowledge of the facts giving rise to their claim for relief. Plaintiff and the  
8 proposed Class did not discover, nor could they have discovered through the exercise of  
9 reasonable diligence, the existence of Defendants' conspiracy until shortly before filing  
10 this complaint.

11 213. Through Defendants' knowing and active concealment of their misconduct,  
12 Plaintiff and the proposed Class did not receive information that should have put them,  
13 or any reasonable person or provider standing in their shoes, on sufficient notice of  
14 collusion worthy of further investigation.

15 214. Plaintiff and the proposed Class could not have been on inquiry notice of  
16 MultiPlan's scheme and the extent and effect of the MultiPlan Cartel until the New  
17 York Times published concerns about MultiPlan's practices, based on recently unsealed  
18 confidential documents in other litigation, on April 7, 2024.

19 215. Even if notice had arisen earlier, an ordinary person acting reasonably  
20 diligently would not have had the time, resources, or specialized training to uncover the  
21 misconduct that Plaintiff, through counsel highly experienced in antitrust class action  
22 litigation, alleges herein, earlier than May 2024.

23 216. Plaintiff exercised reasonable diligence at all times and could not have  
24 discovered Defendants' alleged misconduct sooner because of Defendants' deceptive and  
25 secretive actions to conceal their misconduct.

26 217. Plaintiff filed this claim as soon as it became aware of the anticompetitive  
27 conduct alleged herein, in reliance on its counsel's investigation.  
28

218. Defendants' fraudulent concealment of their wrongful misconduct has tolled and suspended the running of the statute of limitations concerning the claims and rights of action of Plaintiff arising from the conspiracy, including all parts of the class period earlier in time than the four years immediately preceding the date this action was filed.

219. Defendants' misconduct also constitutes a continuing violation against Plaintiff and the proposed Class. Although formed before 2020, the conspiracy has continued thereafter. Defendants continue to engage in the anticompetitive conduct alleged herein and have taken no affirmative steps to withdraw from it or otherwise disavow it.

## **X. ANTICOMPETITIVE EFFECTS AND IMPACT ON INTERSTATE COMMERCE**

220. The MultiPlan Cartel directly damages Plaintiff's business and property and restrains competition in the relevant market. Plaintiff has sustained and continues to sustain economic losses—the full amount of which Plaintiff will calculate after discovery and prove at trial—due to Defendants' artificial suppression of reimbursement rates for out-of-network healthcare services.

221. But for Defendants' conspiracy to fix the price paid for out-of-network healthcare services, Plaintiff and members of the proposed Class would have received higher reimbursement rates for out-of-network healthcare services.

222. While the conspiracy continues, Plaintiff and proposed Class members will continue to suffer losses.

223. The antitrust laws aim to prevent injuries such as those alleged here that stem from a conspiracy among buyers to systematically suppress the price paid for a good or service, such as out-of-network healthcare services. Agreements to reduce price competition or fix prices violate the antitrust laws.

224. The outsourcing of both insurers' rate-setting decisions and claims negotiation responsibilities, as well as Defendants' anticompetitive information

1 exchange, has corrupted the market for out-of-network provider services, replacing  
2 independent centers of decision-making with a single effective decisionmaker,  
3 MultiPlan, and disrupting the competitive process. Insurers' collective use of  
4 MultiPlan's repricing services to set artificially low reimbursement rates subverts the  
5 competitive process by depriving the market of "independent centers of decisionmaking"  
6 and replacing them with decision-making on prices by one shared pricing "brain."

7       225. Economic theory and antitrust jurisprudence show that such joint  
8 delegation schemes, particularly when accompanied by information exchange, reduce  
9 the intensity of price competition and artificially suppresses compensation below  
10 competitive levels. In recent guidance to human resources professionals, the  
11 Department of Justice Antitrust Division ("DOJ") stated that "[s]haring information  
12 with competitors about terms and conditions of employment" can be anticompetitive in  
13 that it decreases competition below competitive levels by allowing firms to match each  
14 other's compensation rather than compete for services by offering additional  
15 compensation.

16       226. That is precisely what has happened with respect to the prices insurers  
17 pay for out-of-network care consumed by their subscribers. As a result of the MultiPlan  
18 Cartel, reimbursement rates provided to healthcare providers, including Plaintiff, for  
19 out-of-network claims have been suppressed below competitive levels.

20       227. According to an April 2020 study published by the Office of the New York  
21 State Comptroller, depending on the service provided, out-of-network reimbursements  
22 paid based upon MultiPlan's repricing methodology were 1.5 to 49 times lower than  
23 UCR-based reimbursements for the same services. And whereas prior to 2016,  
24 reimbursement rates typically rose over time, since 2016 they have fallen year-over-  
25 year.

26       228. The suppression of out-of-network reimbursement rates caused by the  
27 MultiPlan Cartel also indirectly suppresses in-network rates by undermining the ability  
28 of providers to leave insurance networks if in-network rates fall too low, a key form of

1 leverage providers would have in the negotiation of those in-network rates in the  
 2 absence of the MultiPlan Cartel. Because of the Cartel, even if providers attempt to  
 3 leave insurance networks and bill subscribers on an out-of-network basis based on the  
 4 prevailing market rate, MultiPlan ensures that they will receive reimbursement  
 5 amounts that are roughly equal to in-network rates and which are unreasonably low.  
 6 By undermining the economic viability of providers performing services on an out-of-  
 7 network basis, insurers strip providers of a key form of leverage—the ability to decline  
 8 network participation if in-network rates are too low—thereby suppressing in-network  
 9 reimbursement rates.

10 229. By reason of the unlawful activities alleged herein, Defendants  
 11 substantially affected interstate trade and commerce throughout the United States, and  
 12 caused antitrust injury to Plaintiff and members of the proposed Class.

### 13 **XI. CLASS ACTION ALLEGATIONS**

14 230. Plaintiff brings this action on behalf of itself, and all others similarly  
 15 situated, pursuant to Federal Rules of Civil Procedure 23(a), 23(b)(2), and 23(b)(3) as  
 16 representatives of the proposed Class, which is defined as follows:

17 All healthcare providers and practices in the United States and  
 18 its territories that submitted claims for out-of-network  
 19 healthcare services to any third-party payer that used  
 20 MultiPlan's repricing services, including but not limited to the  
 21 Insurer Defendants (or any division, subsidiary, predecessor,  
 22 agent, or affiliate thereof) before the date of trial in this case,  
 and were reimbursed for those claims after MultiPlan's  
 "repricing" of such claims.

23 Excluded from the proposed Class are Defendants and third-party payers who used  
 24 MultiPlan's repricing services (and their officers, directors, management, employees,  
 25 affiliates, parent companies, and subsidiaries) and all governmental entities.

26 231. The proposed Class is so numerous that joinder of all members in this  
 27 action is impracticable. There are tens of thousands if not hundreds of thousands of  
 28 members in the proposed Class.

232. Plaintiff's claims are typical of those of the proposed Class because Plaintiff presses the same legal theories, and seeks to redress the same injury, for itself as for all members of the proposed Class.

233. Plaintiff and all members of the proposed Class were all injured by the same unlawful conduct, which resulted in all of them receiving lower rates of reimbursement on out-of-network claims than they otherwise would have in a competitive market.

234. Plaintiff will fairly and adequately protect and represent the interests of the proposed Class. The interests of the Plaintiff are not antagonistic to the proposed Class.

235. Questions of law and fact common to the members of the proposed Class predominate over questions, if any, that may affect only individual members.

236. Defendants have acted and refused to act on grounds generally applicable to members of the proposed Class, such that injunctive and declaratory relief are appropriate with respect to the proposed Class as a whole.

237. Questions of law and fact common to the proposed Class include but are not limited to:

- whether Defendants have entered into a contract, combination, conspiracy, or common understanding to artificially suppress reimbursement rates for out-of-network claims;
- whether, if Defendants entered into such a contract, combination, conspiracy, or common understanding, that conduct is a *per se* violation of Section 1 of the Sherman Act;
- whether Defendants' conduct has in fact artificially suppressed prices paid on out-of-network claims to members of the proposed Class;
- the proper measure of damages for the proposed Class; and
- the contours of appropriate injunctive relief to remediate the anticompetitive effects of the challenged conduct in the future.

238. Plaintiff is represented by counsel who are experienced and competent in the prosecution of complex antitrust and unfair competition class actions.

239. Class action treatment is the superior method for the fair and efficient adjudication of the controversy in that, among other things, such treatment will permit a large number of similarly situated persons or entities to prosecute their common claims in a single forum simultaneously, efficiently, and without the unnecessary duplication of effort and expense that numerous individual actions would engender. The benefits of proceeding through the class mechanism, including providing injured persons or entities with a method of obtaining redress for claims that might not be practicable for them to pursue individually, substantially outweigh any difficulties that may arise in the management of this class action.

## **XII. CAUSES OF ACTION**

### **COUNT ONE**

#### **Agreement in Restraint of Trade in Violation of**

##### **Section 1 of the Sherman Antitrust Act**

240. Plaintiff incorporates each allegation above as if fully set forth herein.

241. Plaintiff seeks monetary and injunctive relief on behalf of itself and all other members of the proposed Class under Sections 4 and 16 of the Clayton Antitrust Act for Defendants' conduct in violation of Section 1 of the Sherman Act.

242. Defendants, directly and through their divisions, subsidiaries, agents, and affiliates, engage in interstate commerce in the purchase and reimbursement of out-of-network healthcare services for subscribers, and in the sale of health insurance plans.

243. Beginning in or around 2015, Defendants entered into and engaged in an unlawful contract, combination, or agreement, in restraint of interstate trade and commerce in violation of the Sherman Act, 15 U.S.C. § 1.

244. Specifically, Defendants have combined to form a cartel to artificially suppress out-of-network reimbursement rates paid to healthcare providers across the

1 United States and exchanged non-public and competitively sensitive information with  
2 one another in order to accomplish that purpose.

3 245. Defendants' conduct was undertaken with the intent, purpose, and effect of  
4 artificially suppressing out-of-network reimbursement rates below the competitive  
5 level.

6 246. Defendants perpetrated this scheme with the specific intent of decreasing  
7 reimbursement rates for their own benefit.

8 247. Defendants' conduct in furtherance of the unlawful scheme described  
9 herein was authorized, ordered, or executed by their officers, directors, agents,  
10 employees, or representatives while actively engaging in the management of  
11 Defendants' affairs.

12 248. Defendants' Cartel has caused Plaintiff and the proposed Class to suffer  
13 damages in the form of artificially suppressed reimbursement rates.

14 249. The contract, combination, or conspiracy alleged herein has taken the form  
15 of a horizontal conspiracy between competitors in the market for healthcare provider  
16 services.

17 250. In furtherance of this contract, combination, or conspiracy, Defendants  
18 have committed various acts, including as follows:

- 19 • The Insurer Defendants provided real-time, private,  
20 confidential, and detailed internal claims data to  
21 MultiPlan for use in MultiPlan's out-of-network claim  
repricing tools.
- 22 • MultiPlan sold and operated its out-of-network claim  
23 repricing tool that repriced the reimbursement rate for out-  
of-network healthcare services claims.
- 24 • Defendants knowingly used the same out-of-network claim  
25 repricing tool that incorporated other Defendants' real-  
26 time, private, confidential, and detailed internal claims  
27 data to calculate reimbursement rates for out-of-network  
28 healthcare services claims.

- The Insurer Defendants paid reimbursements for out-of-network healthcare services claims at the rates recommended by MultiPlan's repricing tool.
- The Insurer Defendants outsourced out-of-network claims handling to MultiPlan knowing that MultiPlan would set the reimbursement rate of out-of-network healthcare claims at the rates recommended by its repricing tool.
- Defendants exchanged sensitive, real-time, private, confidential, and detailed internal claims data with each other, including by using the MultiPlan out-of-network claims repricing tool.
- Defendants used many forms and methods of bilateral and multilateral communication across various settings and venues concerning the reimbursement rate for out-of-network healthcare services claims, including their use of MultiPlan's out-of-network claim repricing tool, which had the purpose and effect of maintaining and reinforcing their anticompetitive scheme.

251. There are no procompetitive justifications for Defendants' Cartel, and any proffered justifications, to the extent cognizable, could be achieved through less restrictive means.

252. Defendants' Cartel is unlawful under a *per se* mode of analysis. In the alternative, Defendants' Cartel is unlawful under either a quick look or rule of reason mode of analysis.

253. As a direct and proximate result of Defendants' unlawful scheme, Plaintiff and the members of the proposed Class have suffered injury to their business or property and will continue to suffer economic injury and deprivation of the benefit of free and fair competition unless Defendants' conduct is enjoined.

254. Plaintiffs and the proposed Class are entitled to recover three times the damages sustained by them, interest on those damages, together with reasonable attorney's fees and costs under Section 4 of the Clayton Act, 15 U.S.C. § 15.

255. Plaintiffs and the proposed Class are entitled to a permanent injunction that terminates the unlawful conduct alleged herein, as well as any other equitable relief the Court deems proper.

**XIII. PETITION FOR RELIEF**

256. Plaintiff petitions for the following relief:

- a) A determination that this action may be maintained as a class action pursuant to Federal Rule of Civil Procedure 23, that Plaintiff be appointed as class representative, and that Plaintiff's counsel be appointed as class counsel;
- b) A determination that the conduct set forth herein is unlawful under Section 1 of the Sherman Antitrust Act;
- c) A judgment and order requiring the Defendants to pay damages to Plaintiff and members of the proposed Class, trebled;
- d) An order enjoining the Defendants from engaging in further unlawful conduct;
- e) An award of attorneys' fees and costs;
- f) An award of pre- and post-judgment interest on all amounts awarded; and
- g) Such other and further relief as the Court deems just and equitable.

**XIV. JURY DEMAND**

257. Plaintiff, on behalf of itself and the proposed Class, demands a jury trial on all issues triable as of right before a jury.

Respectfully submitted,

Dated: May 17, 2024

By: /s/ Natasha J. Fernández-Silber

Natasha J. Fernández-Silber (*pro hac vice*  
*forthcoming*)\*

nfernandezsilber@edelson.com

Julian Zhu (SBN 342744)

jzhu@edelson.com

EDELSON PC

350 North LaSalle Street, 14th Floor

Chicago, Illinois 60654

Tel: 312.589.6370

Fax: 312.589.6378

\* Admitted to practice in Michigan and New York

By: /s/ Yaman Salahi

Yaman Salahi (SBN 288752)  
ysalahi@edelson.com  
EDELSON PC  
150 California Street, 18th Floor  
San Francisco, California 94111  
Tel: 415.212.9300  
Fax: 415.373.9435

*Counsel for Plaintiff Panoramic Medicine  
and the Proposed Class*

**ATTESTATION OF ELECTRONIC SIGNATURE**

I hereby attest that pursuant to N.D. Cal. Civil L.R. 5-1(i)(3), I have obtained authorization from the above signatories to file the above-referenced document, and that the above signatories concur in the filing's content.

/s/ Yaman Salahi  
Yaman Salahi